Hearing Date: July 28, 2011
j:\mandates\irc\2005/05-4282-I-02\FSA

ITEM 9

INCORRECT REDUCTION CLAIM
FINAL STAFF ANALYSIS

Government Code Sections 7570-7588

Statutes 1984, Chapter 1747 (AB 3632)
Statutes 1985, Chapter 1274 (AB 882)

California Code of Regulations, Title 2, Sections 60000-60610
(Emergency regulations effective January 1, 1986 [Register 86, No. 1], and re-filed June 30, 1986, designated effective July 12, 1986 [Register 86, No. 28

Handicapped and Disabled Students
Fiscal Years 1997-1998, 1998-1999, 2000-2001
05-4282-I-02 and 09-4282-I-04

County of Orange, Claimant

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Adopted Analysis on Requests to Amend the Parameters and Guidelines for *Handicapped and Disabled Students* (CSM 4282, 00-PGA-03/04)

O'Riordan v. Federal Kemper Life Assurance (2005) 36 Cal.4th 281

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Exhibit A

State of California
COMMISSION ON STATE MANDATES
980 Ninth Street, Suite 300
Sacramento, CA 95814
(916) 323-3562

For Official Use Only
RECEIVED MAY 01 2006 COMMISSION ON STATE MANDATES
Claim No. 05-4282-I-02

INCORRECT REDUCTION CLAIM FORM

Local Agency or School District Submitting Claim

Auditor-Controller
County of Orange

Contact Person

Kim Engelby/Howard Thomas

Telephone No.

(714) 834-7407
(714) 834-5313

Address

515 Sycamore St, 5th Floor
Santa Ana, CA 92702

Representative Organization to be Notified

County of Orange, Auditor-Controller Financial Reporting and Mandated Costs

Attn: Bang Quan
PO Box 567
Santa Ana, CA 92702

This claim alleges an incorrect reduction of a reimbursement claim filed with the state Controller's Office pursuant to section 17561 of the Government Code. This incorrect reduction claim is filed pursuant to section 17551(b) of the Government Code.

CLAIM IDENTIFICATION: Specify Statute or Executive Order

Chapters 1747/84 & 1274/85 - Services to Handicapped Students

Fiscal Year*	Amount of the Incorrect Reduction
1997-98	$759,114
1998-99	$870,701
Total	$1,629,815

*More than one fiscal year may be claimed.

IMPORTANT: PLEASE SEE INSTRUCTIONS AND FILING REQUIREMENTS FOR COMPLETING AN INCORRECT REDUCTION CLAIM ON THE REVERSE SIDE.

Name and Title of Authorized Representative

Denise Steckler, Manager
Financial Reporting and Mandated Costs

Telephone No.

(714) 834-5367

Signature of Authorized Representative

X Denise Steckler

Date

4/28/06

COUNTY OF ORANGE
HEALTH CARE AGENCY

BEHAVIORAL HEALTH SERVICES

JULIETTE A. POULSON, RN, MN
DIRECTOR

MARK A. REFOWITZ
DEPUTY AGENCY DIRECTOR
BEHAVIORAL HEALTH SERVICES

MAILING ADDRESS:
405 W. 5th STREET, 7th Floor
SANTA ANA, CA 92701

TELEPHONE: (714) 834-6032
FAX: (714) 834-5506
E-MAIL: mrefowitz @ochca.com

Excellence
Integrity
Service

April 27, 2006

CERTIFIED MAIL

Paula Higashi, Executive Director
Commission on State Mandates
980 9th Street, Suite 300
Sacramento, CA 95814

Re: Incorrect Reduction Claim
Handicapped and Disabled SB90 Claim (HDS)
Fiscal Years 1997/98 and 1998/99

On May 2, 2003, the County of Orange received remittance advices totaling $1,791,058 resulting from findings from the State Controller Office's (SCO) audit of the County's SB90 *Handicapped and Disabled Students* (HDS) claims for Fiscal Years (FY) 1997/98 and 1998/99. Of this amount, $1,629,815 pertained to medication monitoring services that were at that time disallowed.

In our appeal to the findings of this audit, we cited several sections from the California Code of Regulations, Welfare and Institutions Code, and the Government Code that all mandate medication monitoring as a necessary part of treatment services provided for under Chapter 26.5 of the Government Code, and therefore were implied as claimable under the Parameters and Guidelines for this mandate at that time. The SCO's denial of this appeal was based on the argument that the Parameters and Guidelines specify all activities covered by the mandate, and by not specifically including medication monitoring, this implied that these services were not covered.

However, as a result of a successful HDS test claim by another entity, the Commission on State Mandates issued new parameters and guidelines for this claim on February 17, 2006 that allowed for the reimbursement of medication monitoring services. Based on this action, which validates that medication monitoring is and always has been a mandated activity, the County is thereby submitting this Incorrect Reduction Claim for the previously disallowed medication monitoring expenditures from FY 1997/98 and 1998/99 in the amount of $1,629,815 per Title 2, Division 2, Chapter 2.5, Article 1 of the California Code of Regulations.

In accordance with the claiming instructions, we have enclosed the required copies of the necessary documentation in support of this claim. If you require additional information or have any questions, please contact my office at (714) 834-6032.

Mark A. Refowitz
Deputy Agency Director
Behavioral Health Services

Attachments

MAR/ke

SERVICES TO HANDICAPPED STUDENTS

1. Summary of Chapters 1747/84 and 1274/85

Chapter 1747, Statutes of 1984, added Chapter 26, commencing with § 7570, to Division 7 of Title 1 of the Government Code.

Chapter 1274, Statutes of 1985, amended Government Code § § 7572, 7572.5, 7575, 7576, 7579, 7582, and 7587; amended and repealed § 7583; added § 7586.5 and 7586.7; repealed § 7574 and amended § 5651 of the Welfare and Institutions Code. To the extent that Government Code § 7572 and § 60040, Title 2, Code of California Regulations, require county participation in the mental health assessment for "individuals with exceptional needs," such legislation and regulations impose a new program or higher level of service upon a county. Furthermore, any related county participation in the expanded "Individualized Education Program" (IEP) team and case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed", pursuant to Subdivisions (a), (b), and (c) of Government Code § 7572.5 and their implementing regulations.

The aforementioned mandatory county participation in the IEP process is not subject to the Short Doyle Act, and accordingly, such costs related thereto, are costs mandated by the state and are fully reimbursable within the meaning of § 6, Article XIIIB of the California Constitution.

The provisions of Welfare and Institutions Code § 5651, Subdivision (g), result in a higher level of service within the county Short-Doyle program because pursuant to Government Code § § 7571 and 7576 and their implementing regulations, the mental health services must be included in the county Short-Doyle annual plan. Such services include psychotherapy and other mental health services provided to "individuals with exceptional needs", including those designated as "seriously emotionally disturbed", and required in such individual's IEP.

Such mental health services are subject to the current cost sharing formula of the Short-Doyle Act, through which the state provides ninety (90) percent of the total costs of the Short-Doyle program, and the county is required to provide the remaining ten (10) percent of the funds. Accordingly, only ten (10) percent of such program costs are reimbursable within the meaning of § 6, Article XIIIB of the California Constitution as costs mandated by the state, because the Short-Doyle Act currently provides counties ninety (90) percent of the costs of furnishing those mental health services set forth in Government Code § § 7571 and 7576 and their implementing regulations, and described in the county's Short-Doyle annual plan pursuant to Welfare and Institutions Code § 5651, Subdivision (g).

On April 26, 1990, the Commission on State Mandates determined that Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 resulted in state mandated costs that are reimbursable pursuant to Part 7 (commencing with Government Code § 17500) of Division 4 of Title 2. The Commission determined that county participation in the IEP process is a state mandated program and any related cost is fully reimbursable. Furthermore, any mental health treatment required by an IEP is subject to the Short-Doyle cost sharing formula. Consequently, only the county's Short-Doyle share (i.e., ten percent) of the mental health treatment costs will be reimbursed as costs mandated by the state.

2. Eligible Claimants

Any county incurring increased costs as a result of this mandate is eligible to claim reimbursement of these costs.

3. Appropriations

These claiming instructions are issued following the adoption of the program's amended parameters and guidelines by the Commission on State Mandates. Funds for payment of the 1994/95, 1995/96, 1996/97 costs are made available in state budget acts of these fiscal years.

To determine if this program is funded in subsequent fiscal years, refer to the schedule "Appropriations for State Mandated Cost Programs" in the "Annual Claiming Instructions for State Mandated Costs" issued in September of each year to county auditors.

4. Types of Claims

A. Reimbursement and Estimated Claims

A claimant may file a reimbursement and/or an estimated claim. A reimbursement claim details the costs actually incurred for a prior fiscal year. An estimated claim shows the costs to be incurred for the current fiscal year.

B. Minimum Claim

Government Code § 17564(a) provides that no claim shall be filed pursuant to Government Code § 17561 unless such a claim exceeds $200 per program per fiscal year.

5. Filing Deadline

A. Initial Claims

Initial claims must be filed within 120 days from the issuance date of claiming instructions. Accordingly:

(1) Reimbursement claims detailing the actual costs incurred for the 1994/95 and 1995/96 fiscal years must be filed with the State Controller's Office and post- marked by July 28, 1997. If the reimbursement claim is filed after the deadline of July 28, 1997, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

(2) Estimated claims for costs to be incurred during the 1996/97 fiscal year must be filed with the State Controller's Office and postmarked by July 28, 1997. Timely filed estimated claims are paid before late claims. If a payment is received for the estimated claim, a 1996/97 reimbursement claim must be filed by November 30, 1997.

B. Annually Thereafter

Refer to the item "Reimbursable State Mandated Cost Programs" contained in the annual cover letter for mandated cost programs issued annually in September, which identifies the fiscal years for which claims may be filed. If an "x" is shown for the program listed under "19__/19__ Reimbursement Claim," and/or "19__/19__ Estimated Claim," claims may be filed as follows:

(1) An estimated claim must be filed with the State Controller's Office and postmarked by November 30 of the fiscal year in which costs are to be incurred. Timely filed estimated claims will be paid before late claims.

After having received payment for an estimated claim, the claimant must file a reimbursement claim by November 30 of the following fiscal year. If the local agency fails to file a reimbursement claim, monies received for the estimated claim must be returned to the State. If no estimated claim was filed, the agency may file a reimbursement claim detailing the actual costs incurred for the fiscal year, provided there was an appropriation for the program for that fiscal year. For information regarding appropriations for reimbursement claims, refer to the "Appropriation for State Mandated Cost Programs" in the previous fiscal year's annual claiming instructions.

(2) A reimbursement claim detailing the actual costs must be filed with the State Controller's Office and postmarked by November 30 following the fiscal year in which costs were incurred. If the claim is filed after the deadline but by November 30 of the succeeding fiscal year, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

6. Reimbursable Components

Eligible claimants will be reimbursed for the direct and indirect cost of labor, supplies, and services incurred for the following mandated components:

A. Assessment, IEP Participation, Case Management

(1) The scope of the mandate is one hundred percent (100) percent reimbursement of any costs related to IEP Participation, Assessment, and Case Management, except for individuals billed to Medi-Cal only. The Federal Financing Participation portion (FFP) for these activities should be deducted from reimbursable activities not subject to the Short-Doyle Act.

(2) For each eligible claimant, the following cost items are one hundred (100%) percent reimbursable (G. C. § 7572, subd. (d)(1)):

(a) Whenever an LEA refers an individual suspected of being an "individual with exceptional needs" to the local mental health department, mental health assessment and recommendation by qualified mental health professionals in conformance with assessment procedures set forth in Article 2 (commencing with § 56320) of Chapter 4 of part 30 of Division 4 of the Education Code, and regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, including but not limited to the following mandated services:

i. Interview with the child and family

ii. Collateral interviews as necessary

iii. Review of the records

iv. Observation of the child at school

v. Psychological testing and/or psychiatric assessment, as necessary.

(b) Review and discussion of mental health assessment and recommendations with parent and appropriate IEP team members. (G. C. § 7572, subd. (d)(1)).

(c) Attendance by the mental health professional who conducted the assessment at IEP meetings, when requested. (G. C. § 7572, subd. (d)(1)).

(d) Review by claimant's mental health professional of any independent assessment(s) submitted by the IEP team. (G. C. 7572, subd. (d)(2)).

(e) When the written mental health assessment report provided by the local mental health program determines that an "individual with special needs" is seriously

emotionally disturbed", and any member of the IEP team recommends residential placement based upon relevant assessment information, inclusion of the claimant's mental health professional on that individual's expanded IEP team.

(f) When the IEP prescribes residential placement for an "individual with exceptional needs" who is "seriously emotionally disturbed," claimant's mental health personnel's identification of out-of-home placement, case management, six month review of IEP, and expanded IEP responsibilities. (G. C. § 7572.5).

(g) Required participation in due process procedures, including but not limited to due process hearings.

(b) One hundred (100%) percent of any administrative costs related to IEP Participation, Assessment, and Case Management, whether direct or indirect.

B. Treatment Services

Any costs related to mental health treatment services rendered under the Short-Doyle Act:

(1) The scope of the mandate is ten (10%) percent reimbursement.

(2) For each eligible claimant, the following cost items for the provision of mental health services when required by a child's individualized education program are ten (10%) percent reimbursable (G. C. § 7576):

(a) Individual therapy

(b) Collateral therapy and contacts

(c) Group therapy

(d) Day treatment

(e) Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.

(b) Ten (10%) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

7. Reimbursement Limitations

A. Any offsetting savings the claimant experiences as a direct result of this statute must be deducted from the costs claimed.

B. The following reimbursements for this mandate shall be deducted from the claim:

1. Any direct payments (categorical funding) received form the State which are specifically allocated to this program.
2. Any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g., federal, state, etc.

8. Claiming Forms and Instructions

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms HDS-1, HDS-2, HDS-3, HDS-4, HDS-5, and HDS-6 provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions should be duplicated and used by the claimant to file estimated or reimbursement claims. The State Controller's Office will revise the manual and claim forms as necessary. In such instances, new replacement forms will be mailed to claimants.

9. Claim Preparation

There are two satisfactory methods of submitting claims for reimbursement of increased costs incurred to comply with the mandate:

A. Cost Report Method

Under this claiming method a complete copy of the annual cost report including all supporting schedules attached to the cost report as filed with DMH must also be filed with the claim forms submitted to the State Controller.

To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions:

Ten (10%) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs that exceed ten (10%) percent of total program direct labor costs, excluding fringe benefits.

OR if an indirect cost rate greater than ten (10%) is being claimed:

By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations that further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program, each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP's.

1. **Form HDS-6, Component/Activity Cost Detail**

   This form is used to detail the cost of administration for Assessment, IEP Participation, Case Management and Mental Health Treatment. The indirect costs summarized on this form must be carried forward to HDS-3, line (03)(e) or HDS-3, line (03)(g), as appropriate.

   Indirect costs may be computed as ten (10%) of direct labor costs, excluding fringe benefits. If an indirect cost rate greater than ten (10%) is used, include the Indirect Cost Proposal (ICRP) with the claim. If more than one department is involved in the mandated costs program, each department must have their own ICRP.

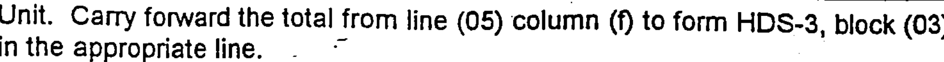
2. **Form HDS-5, Component/Activity Cost Detail**

   This form is used to detail the cost of due process proceedings. Claim statistics shall identify the amount of work performed during the period in which costs are claimed. The claimant must provide the number of due process proceedings. The cost summarized on this form must be carried forward to HDS-3, line (03)(d).

   Indirect costs may be computed as ten (10%) of direct labor costs, excluding fringe benefits. If an indirect cost rate greater than ten (10%) is used, include the Indirect Cost Proposal (ICRP) with the claim. If more than one department is involved in the mandated costs program, each department must have their own ICRP.

3. **Form HDS-4, Component/Activity Cost Detail**

   This form is used to segregate the detailed cost by claim component. Information required to complete this form: (a) Name of Providers, (b) Provider I.D. Numbers, (c) Service Function Codes, (d) Units of Service, and (e) Rate Per



Unit. Carry forward the total from line (05) column (f) to form HDS-3, block (03) in the appropriate line.

4. **Form HDS-3, Claim Summary**

This form is used to summarize the cost from forms HDS-4, HDS-5, and HDS-6. The cost must be reduced by the amount of funds received from Non-Categorical State General/Realignment Funds, State Categorical Funds, Short-Doyle/Medi Cal (FFP only), and other funds that reimburse any portion of the mandate. The total claimed amount on this form is carried forward to form FAM-27.

B. **Actual Increased Cost Method**

Report actual increased costs incurred for each of the following expense categories in the format specified by the State Controller's claiming instructions. Attach supporting schedules as necessary.

1. **Form HDS-2, Component/Activity Cost Detail**

This form is used to segregate the detailed cost by claim component. A separate form HDS-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(a) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed by each employee and specify the actual time spent, the productive hourly rate and related fringe benefits.

Source documents required to be maintained by the claimant may include, but are not limited to, employee time records that show the employee's actual time spent on this mandate.

(b) Materials and Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of materials consumed or expended specifically for the purpose of this mandate.

Source documents required to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase orders and other documents evidencing the validity of the expenditures.

(c) Contracted Services

Contracting costs are reimbursable to the extent that the function to be performed requires special skill or knowledge that is not readily available from the claimant's staff or the service to be provided by the contractor is cost effective. Use of contract services must be justified by the claimant.

Give the name(s) of the contractor(s) who performed the services. Describe the activities performed by each named contractor, actual time spent on this mandate, inclusive dates when services were performed, and itemize all costs for services performed. Attach consultant invoices with the claim.

Source documents required to be maintained by the claimant may include, but are not limited to, contracts, invoices, and other documents evidencing the validity of the expenditures.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

2. **Form HDS-1, Claim Summary**

This form is used to summarize direct costs by cost component and compute allowable indirect costs for the mandate. Direct costs summarized on this form are derived from form HDS-2 and carried forward to form FAM-27.

One hundred (100%) of any indirect administrative costs related to IEP participation, assessment, case management, and ten percent (10%) of mental health treatment rendered under the Short-Doyle Act may be claimed to the extent that reimbursable indirect costs have not already been reimbursed by the DMH. Indirect costs may be claimed using either of two methods:

(a) Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs which exceed ten (10) percent of total program direct labor costs, excluding fringe benefits.

OR if an indirect cost rate greater than ten (10) percent is being claimed,

(b) By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program, each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP's.

C. **Form FAM-27, Claim for Payment**

This form contains a certification that must be signed by an authorized representative of the local agency. All applicable information from form HDS-1 or HDS-3 must be carried forward to this form for the State Controller's Office to process the claim for payment.

Illustration of Claim Forms

A. Cost Report Method

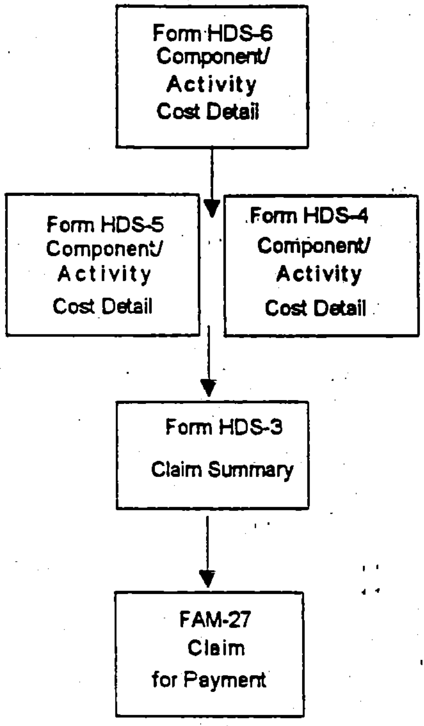
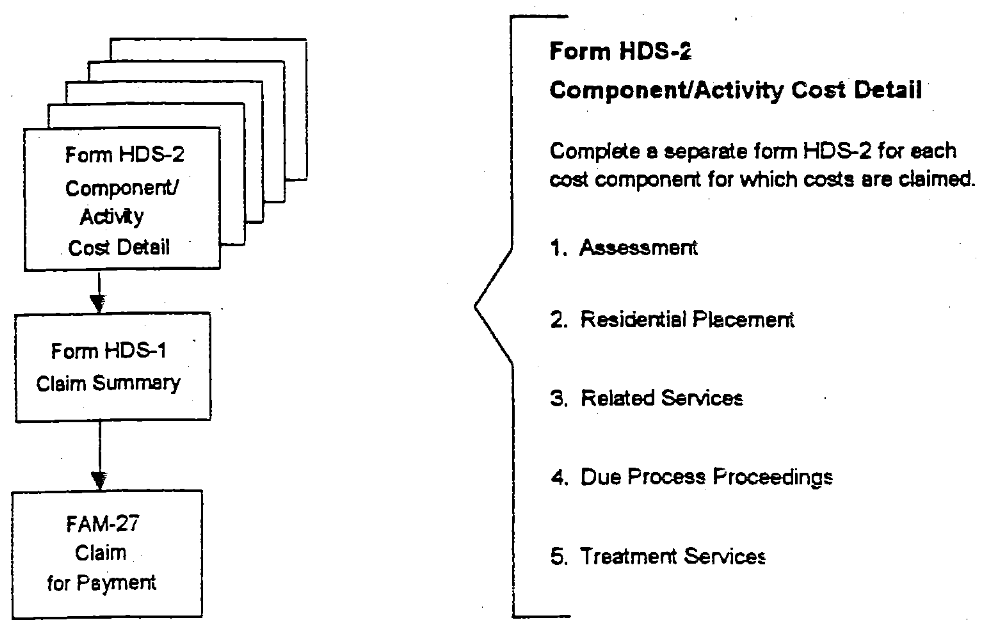


Illustration of Claim Forms

B. Actual Report Method



CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SERVICES TO HANDICAPPED STUDENTS

For State Controller Use Only
(19) Program Number 00111
(20) Date File ___/___/___
(21) LRS Input ___/___/___

LABEL HERE

(01) Claimant Identification Number	Reimbursement Claim Data
(02) Mailing Address	(22) HDS-1, (03)(a)
Claimant Name	(23) HDS-1, (03)(b)
County of Location	(24) HDS-1, (03)(c)
Street Address or P. O.. Box	(25) HDS-1, (04)(1)(d)
City State Zip Code	(26) HDS-1, (04)(2)(d)

Type of Claim	Estimated Claim	Reimbursement Claim		
	(03) Estimated ☐	(09) Reimbursement ☐	(27) HDS -1, (04)(3)(d)	
	(04) Combined ☐	(10) Combined ☐	(28) HDS-1, (04)(4)(d)	
	(05) Amended ☐	(11) Amended ☐	(29) HDS-1, (04)(5)(d)	
			(30) HDS-1, (06)	
Fiscal Year of Cost	(06) 19___/19___	(12) 19___/19___	(31) HDS-3, (05)	
Total Claimed Amount	(07)	(13)	(32) HDS-3, (06)	
Less: 10% Late Penalty, not to exceed $1,000		(14)	(33) HDS-3, (07)	
Less: Estimated Claim Payment Received		(15)	(34)	
Net Claimed Amount		(16)	(35)	
Due from State	(08)	(17)	(36)	
Due to State		(18)	(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 set forth on the attached statements.

Signature of Authorized Representative ______________________ Date ______________________

______________________ ______________________

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number ( ) - Ext.

SERVICES TO HANDICAPPED STUDENTS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form HDS-1 and enter the amount from line (11) or complete form HDS-3 and enter the amount from line (15).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form HDS-1, line (11) or from form HDS-3, line (15), as appropriate.

(14) Filing Deadline. Amended Claims of Ch.1747/84 and Ch.1274/85. If the reimbursement claim for the 1994/95 or 1995/96 fiscal year is filed after July 28, 1997, the additional amount over the original claim must be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

Filing Deadline. Annually Thereafter. If the reimbursement claim is filed after November 30 following the fiscal year in which costs were incurred, the claim must be reduced by a late penalty.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (33) for the reimbursement claim [e.g., HDS-1 (03)(a), means the information is located on form HDS-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). The claim cannot be processed for payment unless this data block is correct and complete.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND ONE COPY OF FORM FAM-27, AND ONE COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by:
U.S. Postal Service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursement Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by:
Other delivery service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursement Section
Division of Accounting and Reporting
3301 C Street, Suite 501
Sacramento, CA 95816

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY	FORM HDS-1

(01) Claimant	(02) Type of Claim Reimbursement ☐ Estimated ☐	Fiscal Year 19__/19__

Claim Statistics

(03)(a) Number of students who were suspected of being "individuals with exceptional needs," and were referred to the local mental health department for assessment and recommendation in the fiscal year of claim.	
(b) Number of students who required residential placements in the fiscal year of claim.	
(c) Number of due process proceedings that took place in the fiscal year of claim.	

Direct Costs

(04) Reimbursable Components:	(a) Salaries	(b) Benefits	(c) Services and Supplies	(d) Total
1. Assessment				
2. Residential Placement				
3. Related Services				
4. Due Process Proceedings				
5. Treatment Services				
(05) Total Direct Costs				

Indirect Costs

(06) Indirect Cost Rate	[From ICRP]	%
(07) Total Indirect Costs	[Line (06) x line (05)(a)] or [line (06) x [line (05)(a) + line (05)(b)]]	
(08) Total Direct and Indirect Costs	[Line (05)(d) + line (07)]	

Cost Reduction

(09) Less: Offsetting Savings, if applicable		
(10) Less: Other Reimbursements, (i.e., State General/Realignment Funds, State Categorical Funds, Short-Doyle/Medi-Cal (FFP only), etc.)		
(11) Total Claimed Amount	[Line (08) - {Line (09) + line (10)}]	

SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY Instructions	FORM HDS-1

(01) Enter the name of the claimant. If more than one department has incurred costs for this mandate, give the name of each department. A form HDS-1 should be completed for each department

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form HDS-1 must be filed for a reimbursement claim. Do not complete form HDS-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form HDS-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) (a) Enter the number of students who were suspected of being "individuals with exceptional needs," and were referred to the local mental health department for assessment and recommendation in the fiscal year of claim.
(b) Enter the number of students who required residential placements in the fiscal year of claim.
(c) Enter the number of due process proceedings that took place in the fiscal year of claim.

(04) Reimbursable Components: For each reimbursable component , enter the totals from form HDS-2, line (05) columns (d), (e), and (f) to form HDS-1, block (04) columns (a), (b), and (c) in the appropriate row. Total each row.

(05) Total Direct Costs. Total columns (a) through (d).

(06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.

(07) Total Indirect Costs. Multiply Total Salaries, line (05)(a) by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply total Salaries and Benefits, line (05)(a) and line (05)(b) by the Indirect Cost Rate, line (06).

(08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(d) and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source, [i.e., State General/Realignment Funds, State Categorical Funds, Short-Doyle/Medi-Cal (FFP only), service fees collected, federal funds, other state funds, etc.,] which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09) and Other Reimbursements, line (10) from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL

FORM HDS-2

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Check **only** one box per form to identify the component being claimed

☐ Assessment
☐ Due Process Proceedings
☐ Residential Placement
☐ Treatment Services
☐ Related Services

(04) Description of Expenses: Complete columns (a) through (f).

(a) Employee Names, Job Classifications, Functions Performed and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	Object Accounts (d) Salaries	(e) Benefits	(f) Services and Supplies
(05) Total ☐ Subtotal ☐ Page:_____ of_____					

SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL
Instructions

FORM HDS-2

(01) Enter the name of the claimant. If more than one department has incurred costs for this mandate, give the name of each department. A form HDS-2 should be completed for each department.

(02) Enter the fiscal year in which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form HDS-2 shall be prepared for each component which applies.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in line (03), enter the employee names, position titles, a brief description of their activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contracted services, etc. The **descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed. If the descriptions are incomplete, the claim cannot be processed for payment.** For audit purposes, all supporting documents must be retained by the claimant for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub-object Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name Title	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits	Activities Performed	Benefit Rate		Salaries	Benefits = Benefit Rate x Salaries		
Services and Supplies Office Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Consumed	
Contracted Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Itemize Cost of Services Performed	Invoice

(05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed for the component/activity, number each page. Enter totals from line (05), columns (d), (e), and (f) to form HDS-1, block (04), columns (a), (b), and (c) in the appropriate row.

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY	FORM HDS-3

(01) Claimant	(02) Type of Claim Reimbursement ☐ Estimated ☐	Fiscal Year 19___/19___

(03) Reimbursable Components	
Assessment of Individuals With Exceptional Needs	
(a) Assessment: Interviews, Review of Records, Observations, Testing, etc.	
(b) Residential Placement: IEP Reviews, Case Management, and Expanded IEP	
(c) Related Services: Attendance at IEP meetings, Meeting with IEP Members and Parents, and Review of Independent Assessment.	
(d) Due Process Proceedings	
(e) Administrative Costs	
Mental Health Treatment	
(f) Treatment Services: Short-Doyle Program	
(g) Administrative Costs	
(04) Sub-total for Assessment of Individual with Exceptional Needs [Sum of (03), lines (a) to (e)]	
(05) Less: Amount Received from Short-Doyle/Medi-Cal (FFP only)	
(06) Less: Amount Received from State Categorical Funding	
(07) Less: Amount Received from Other (Identify)	
(08) Total for Assessment of Individual with Exceptional Needs [Line (04) minus the sum of lines (05) to (07)]	
(09) Sub-Total for Mental Health Treatment [block (03), lines (f) and (g)]	
(10) Less: Non-Categorical State General/Realignment Funds	
(11) Less: Amount Received from State Categorical Funds	
(12) Less: Amount Received from Short-Doyle/Medi-Cal (FFP only)	
(13) Less: Amount Received from Other (Identify)	
(14) Total Mental Health Treatment [Line (09) minus the sum of lines (10) to (13)]	
(15) Total Claimed Amount [Sum of line (08) and line (14)]	

SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY Instructions	FORM HDS-3

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form HDS-3 must be filed for a reimbursement claim. Do not complete form HDS-3 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form HDS-3 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Reimbursable Components. For each reimbursable component under block (03), lines (a), (b), and (c), enter the totals from form HDS-4, line (05) column (f), as applicable. For block (03), line (d), enter the cost from form HDS-5, line (08), if applicable. For block (03), lines (e) and (g), enter the cost from HDS-6, line (08), as appropriate.

(04) Sub-Total for Assessment of Individual with Exceptional Needs. Enter the sum of the amounts on block (03), lines (a), (b), (c), (d), and (e).

(05) Less: Amount Received from Short-Doyle/Medi-Cal (Federal Financial Participation only). From line 72, "Medi-Cal Federal", the Department of Mental Health Cost Reporting/Data Collection System, "Local Services Cost Report", form MH 1944, enter the sum of amounts shown for providers listed on form HDS-4, block (04)(a).

(06) Less: Amount Received from State Categorical Funding. Enter the total amount received from the State General Fund for special education.

(07) Less: Amount Received from Other (Identify). Enter the total amount received from sources which reimbursed the cost of this mandate (e.g., Patient health insurance, etc.). Attach a separate schedule identifying those funding sources.

(08) Total for Assessment of Individual with Exceptional Needs. Enter the result of subtracting the sum of lines (05), (06), and (07) from line (04).

(09) Sub-Total for Mental Health Treatment. Enter the sum of the amount from block (03), lines (f) and (g).

(10) Less: Non-Categorical State General/Realignment Funds.

(11) Less: Amount Received from State Categorical Funds. Enter the total amount received from the State General Fund for special education.

(12) Less: Amount Received from Short-Doyle/Medi-Cal (Federal Financial Participation only). From line 72 , "Medi-Cal Federal", the Department of Mental Health Cost Reporting/Data Collection System, "Local Services Cost Report", form MH 1944, enter the sum of amounts shown for providers listed on form HDS-4, block (04)(a).

(13) Less: Amount Received from Other (Identify). Enter the total amount received from sources which reimbursed the cost of this mandate (e.g., Patient health insurance). Attach a separate schedule identifying those funding.

(14) Total Mental Health Treatment. Enter the result of subtracting the sum of lines (10) to (13) from line (09).

(15) Total Claimed Amount. Enter the sum of line (08) and line (14). Carry forward the amount on this line to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL

FORM HDS-4

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Check **only** one box per form to identify the component being claimed

- [ ] Assessment
- [ ] Treatment Services
- [ ] Residential Placement
- [ ] Other (Identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I. D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total

(05) Total [ ] Subtotal [ ] Page:_____ of_____

SERVICES TO HANDICAPPED STUDENTS COMPONENT/ACTIVITY COST DETAIL Instructions	FORM HDS-4

(01) Enter the name of the claimant.

(02) Enter the fiscal year of claim in which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form HDS-4 shall be prepared for each component which applies.

(04) Description of Expenses. For each "checked" component/activity box in block (03), enter the detailed costs for each case claimed.

(a) Enter the name of the provider.

(b) Enter the provider identification number.

(c) Enter the service function codes.

(d) Enter the number of units of service.

(e) Enter the rate per unit.

(f) Enter the total [multiply column (d) times column (e)]

A copy of that portion of the county's Short-Doyle fiscal year end report relating to the amounts claimed must be submitted with the claim.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed, or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

(05) Total line (04) column (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/activity costs, number each page. Carry forward the total from line (05) column (f) to form HDS-3, block (03) in the appropriate line.

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS COMPONENT/ACTIVITY COST DETAIL	FORM HDS-5

(01) Claimant	(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Due Process Proceedings

(04) Description of Expenses: Complete columns (a) through (g).			Object Accounts			
(a) Employee Names, Job Classifications, Functions Performed and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Totals						
(05) Total Direct Costs						
Indirect Costs						
(06) Indirect Cost Rate [From ICRP]						%
(07) Total Indirect Costs [Line (06) x line (05)(d)] or [Line (06) x {(05)(d) + (05)(e)}]						
(08) Total Direct and Indirect Costs [Line (05) + line (07)]						

SERVICES TO HANDICAPPED STUDENTS COMPONENT/ACTIVITY COST DETAIL Instructions	FORM HDS-5

(01) Enter the name of the claimant.

(02) Enter the fiscal year in which costs were incurred.

(03) Reimbursable Components. Due Process Proceedings.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in line (03), enter the employee names, position titles, a brief description of their activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contracted services, etc. Total each column (d) through (g). **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed. If the descriptions are incomplete, the claim cannot be processed for payment.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	**Columns**							**Submit these supporting documents with the claim**
	(a)	**(b)**	**(c)**	**(d)**	**(e)**	**(f)**	**(g)**	
Salaries	Employee Name Title Activities Performed	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked				
Benefits		Benefit Rate		Salaries	Benefits = Benefit Rate x Salaries			
Services and Supplies Office Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Consumed		
Contracted Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service				Itemized Cost of Services Performed	Invoice

(05) Total Direct Costs. Enter the total for columns (d) to (g).

(06) Indirect Cost Rate. Enter the indirect cost rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the department's Indirect Cost Rate Proposal (ICRP) for the program with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.

(07) Total Indirect Costs. Multiply Total Salaries, line (04)(d) by the Indirect Cost Rate, line (06). If both salaries and benefits are used in the distribution base for the computation of the indirect cost rate, then multiply Total Salaries, line (04)(d) and Total Benefits, line (04)(e) by the Indirect Cost Rate, line (06).

(08) Total Direct and Indirect Costs. Enter the sum of line (05) and line (07). Forward the amount to form HDS-1, line (03)(d).

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL

FORM HDS-6

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Administrative Costs

☐ Assessment of Individual ☐ Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).

(a) Employee Names, Job Classifications, Functions Performed and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	Object Accounts (d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Totals						

(05) Total Direct Costs	

Indirect Costs

(06) Indirect Cost Rate	[From ICRP]	%
(07) Total Indirect Costs	[Line (06) x line (04)(d)] or [Line (06) x {(04)(d) + (04)(e)}]	

SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL
Instructions

FORM HDS-6

(01) Enter the name of the claimant.

(02) Enter the fiscal year in which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the administrative cost component (i.e., Assessment of Individuals or Mental Treatment) claimed. A separate form HDS-6 shall be prepared for administrative costs associated with the assessment of individuals with exceptional needs, and for mental health treatment.. Do not include indirect costs for line (03)(d), since the cost should be recorded on form HDS-5.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in line (03), enter the employee names, position titles, a brief description of their activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contracted services, etc. Total each column (d) through (g). **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed. If the descriptions are incomplete, the claim cannot be processed for payment.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns (a)	(b)	(c)	(d)	(e)	(f)	(g)	Submit these supporting documents
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked				
Benefits	Title	Benefit Rate		Salaries	Benefits = Benefit Rate x			
Services and Supplies Office Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity		
Contracted Services	Name of Contractor Specific Tasks	Hourly Rate	Hours Worked Inclusive Dates of				Itemized Cost of Services Performed	Invoice

(05) Total Direct Costs. Enter the total for columns (d) to (g).

(06) Indirect Cost Rate. Enter the indirect cost rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the department's Indirect Cost Rate Proposal (ICRP) for the program with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.

(07) Total Indirect Costs. Multiply Total Salaries, line (04)(d) by the Indirect Cost Rate, line (06). If both salaries and benefits are used in the distribution base for the computation of the indirect cost rate, then multiply Total Salaries, line (04)(d) and Total Benefits, line (04)(e) by the Indirect Cost Rate, line (06). Forward the amount of indirect costs to form HDS-3, line (03)(e) or line (03)(g) as appropriate.

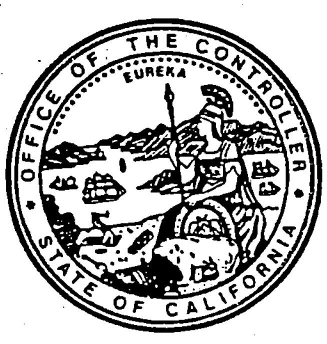
ORANGE COUNTY

Audit Report

HANDICAPPED AND DISABLED STUDENTS PROGRAM

Chapter 1747, Statutes of 1984, and
Chapter 1274, Statutes of 1985

July 1, 1997, through June 30, 1999



KATHLEEN CONNELL
California State Controller

December 2002

KATHLEEN CONNELL

Controller of the State of California

December 26, 2002

The Honorable David E. Sundstrom
Auditor-Controller
Orange County
12 Civic Center Plaza
Santa Ana, CA 92701

Dear Mr. Sundstrom:

The State Controller's Office (SCO) has completed an audit of the claims filed by Orange County for costs of the legislatively mandated Handicapped and Disabled Students Program (Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985) for the period of July 1, 1997, through June 30, 1999.

The county claimed and was paid $22,506,432 for the mandated program. The SCO audit disclosed that $20,715,374 is allowable and $1,791,058 is unallowable. The unallowable costs resulted primarily from the county claiming ineligible costs, which caused an overstatement in the county's Medi-Cal revenue offsets. Consequently, the amount paid in excess of allowable costs claimed, totaling $1,791,058, should be returned to the State.

The above amounts incorporate the fiscal effect of Assembly Bill 2781 (Chapter 1167, Statutes of 2002). The legislation changed the regulatory criteria by stating that the percentage of treatment costs claimed by counties for fiscal year 2000-01 and prior fiscal years is not subject to dispute by the SCO. Consequently, AB 2781 reduced realignment funding and, therefore, increased net reimbursable costs by $10,522,121.

The SCO has established an informal audit review process to resolve a dispute of facts. The auditee should submit, in writing, a request for a review and all information pertinent to the disputed issues within 60 days after receiving the final report. The request and supporting documentation should be submitted to: Richard J. Chivaro, Chief Counsel, State Controller's Office, Post Office Box 942850, Sacramento, CA 94250-0001.

If you have any questions, please contact Jim L. Spano, Chief, Compliance Audits Bureau, at (916) 323-5849.

Sincerely,

Walter Barnes

WALTER BARNES
Chief Deputy State Controller, Finance

WB:wq/jj

cc: Shawn Skelly
Assistant Auditor-Controller
Orange County
Douglas E. Barton, Director
Behavioral Health Department
Orange County
Alice Manning, Deputy Director
Behavioral Health Department
Orange County

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Attachment—Auditee's Response to Draft Audit Report

Audit Report

Summary

The State Controller's Office (SCO) has completed an audit of the claims filed by Orange County for costs of the legislatively mandated Handicapped and Disabled Students Program (Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985) for the period of July 1, 1997, through June 30, 1999. The last day of fieldwork was June 19, 2002.

The county claimed and was paid $22,506,432 in program costs for the audit period. The SCO audit disclosed that $20,715,374 is allowable and $1,791,058 is unallowable. The unallowable costs resulted primarily from the county claiming ineligible costs, which caused an overstatement in the county's Medi-Cal revenue offsets. The amount paid in excess of allowable costs claimed, totaling $1,791,058, should be returned to the State.

Background

Chapter 1747, Statutes of 1984, requires counties to participate in the mental health assessment for "individuals with exceptional needs," participate in the expanded Individualized Education Program (IEP) team, and provide case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed." These requirements impose a new program or a higher level of service upon counties. On April 26, 1990, the Commission on State Mandates determined that Chapter 1747, Statutes of 1984, resulted in state-mandated costs that are reimbursable pursuant to *Government Code* Section 17561.

Parameters and Guidelines, adopted by the Commission on State Mandates, establishes the state mandate and defines criteria for reimbursement. In compliance with *Government Code* Section 17558, the SCO issues claiming instructions for each mandate requiring state reimbursement to assist counties in claiming reimbursable costs.

Objective, Scope, and Methodology

The objective of the audit was to determine whether costs claimed were increased costs incurred as a result of the legislatively mandated Handicapped and Disabled Students Program (Chapter 1747, Statutes of 1984, and Chapter 1747, Statutes of 1985) for the period of July 1, 1997, through June 30, 1999.

The auditors performed the following procedures:

- Reviewed the costs claimed to determine if they were increased costs resulting from the mandated program;
- Traced the costs claimed to the supporting documentation to determine whether the costs were properly supported;
- Confirmed that the costs claimed were not funded by another source; and
- Reviewed the costs claimed to determine that the costs were not unreasonable and/or excessive.

The SCO conducted the audit in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. The SCO did not audit the county's financial statements. The scope was limited to planning and performing audit procedures necessary to obtain reasonable assurance concerning the allowability of expenditures claimed for reimbursement. Accordingly, transactions were examined, on a test basis, to determine whether the amounts claimed for reimbursement were supported.

Review of the county's management controls was limited to gaining an understanding of the transaction flow and claim preparation process as necessary to develop appropriate auditing procedures.

Conclusion

The SCO audit disclosed instances of noncompliance with the requirements outlined above. These instances are described in the Findings and Recommendations section of this report and in the accompanying Summary of Program Costs (Schedule 1).

For the two-year audit period, Orange County claimed $22,506,432 for costs of the legislatively mandated Handicapped and Disabled Students Program. The audit disclosed that $20,715,374 is allowable and $1,791,058 is unallowable.

For fiscal year (FY) 1997-98, the county was paid $10,585,561 by the State. The audit disclosed that $9,789,068 is allowable. The amount paid in excess of allowable costs claimed, totaling $796,493, should be returned to the State.

For FY 1998-99, the county was paid $11,920,871 by the State. The audit disclosed that $10,926,306 is allowable. The amount paid in excess of allowable costs claimed, totaling $994,565, should be returned to the State.

Views of Responsible Officials

The SCO issued a draft audit report on June 28, 2002. David E. Sundstrom, Auditor-Controller, responded by letter dated September 25, 2002, disagreeing with all findings in the draft report. The county's response is included as an attachment to this audit report.

The draft report included audit adjustments totaling $12,374,953. Audit adjustments in this final report have been reduced by $10,583,895, from $12,374,953 to $1,791,058.

Finding 2 of the draft report disclosed that $119,749 was unallowable because the county claimed various mental health services at rates that exceeded the statewide maximum allowance. Based on previous Commission on State Mandates rulings, the SCO determined that actual county costs incurred in excess of California Department of Mental Health statewide maximum rates are allowable. Consequently, the finding has been eliminated from the final report, and Findings 3 through 5 of the draft report have been renumbered as Findings 2 through 4.

The audit adjustment in Finding 4 of this final report has been revised because of the elimination of Finding 2 of the draft report and legislation occurring after the issuance of the draft report that changed the regulatory criteria (discussed in the Findings and Recommendations section). Consequently, rather than understating realignment funding by $10,445,864, the county overstated realignment funding by $76,257, a difference of $10,522,121.

The remaining findings continue to be valid.

Restricted Use

This report is solely for the information and use of Orange County and the SCO; it is not intended to be and should not be used by anyone other than these specified parties. This restriction is not intended to limit distribution of this report, which is a matter of public record.

WALTER BARNES
Chief Deputy State Controller, Finance

Findings and Recommendations

FINDING 1— Ineligible costs claimed

The county claimed various ineligible case management and treatment costs.

The county claimed case management costs for clients placed in out-of-state residential facilities. These costs are not reimbursable under the Handicapped and Disabled Students Program, but rather under the Seriously Emotionally Disturbed Pupils: Out-of-State Mental Health Services Program.

The county also claimed treatment costs for medication support and crisis intervention, which are not reimbursable under program guidelines.

Parameters and Guidelines allows for reimbursement of increased costs incurred for the specific program filed. *Parameters and Guidelines* specifies that the following treatment services are reimbursable: individual therapy; collateral therapy and contacts; group therapy; day treatment; and the mental health portion of residential treatment in excess of the California Department of Social Services' payments for residential placement.

As a result, ineligible treatment and case management costs claimed are unallowable as follows:

	Audit Adjustment		
	FY 1997-98	FY 1998-99	Totals
Case management costs	$ (54,429)	$ (62,869)	$ (117,298)
Treatment costs	(915,082)	(1,023,438)	(1,938,520)
Totals	$ (969,511)	$(1,086,307)	$(2,055,818)

Recommendation

The county should establish procedures to ensure that costs claimed are eligible increased costs incurred as a result of the mandate.

Auditee's Response

The County does not concur. We have established procedures to ensure that costs claimed are eligible increased costs incurred as a result of the mandate, and we have been following those procedures since we started submitting claims for the *Handicapped and Disabled Students Program*. In the narrative below we have responded to the auditor's findings on (a) case management costs for clients placed in out-of-state residential facilities, (b) treatment costs for medication support, and (c) treatment costs for crisis intervention separately.

a) **Case Management costs for clients placed in out-of-state residential facilities.**

The County concurs that these costs are reimbursable under the *Seriously Emotionally Disturbed* (SED) *Pupils: Out-of-State Mental*

Health Services Program, and we have subsequently claimed these costs in the *SED* claim for Fiscal Years 1997-98, 1998-99, 1999-2000, and 2000-01.

However, at the time we filed the *Handicapped and Disabled Students Program* claims for Fiscal Years 1997-98 and 1998-99, which are the years being audited, the *SED Program* had not been identified as a mandated program, and the County believed that these costs were eligible to be claimed as part of the *Handicapped and Disabled Students Program* mandate. Claiming instructions for the *SED Program* were not issued until January 2001.

b) **Treatment Costs for Medication Support.**

The County does not concur that these are ineligible costs.

The *Parameters and Guidelines*, Summary of Mandates; references California Code of Regulations, Division 9, Sections 60000-60200, Title 2, as well as Division 7, Title 1 of the Government Code commencing with Section 7570. The *Parameters and Guidelines* specifically cites Government Code sections 7571 and 7576 <u>and their implementing regulations</u> as governance. The "implementing regulations" for the provision of Chapter 25.6 of the Government Code are found in the California Code of Regulations, Title 2, Division 9, the Joint Regulations for Handicapped Children.

Section 7576 (amended in 1996) of the Government Code identifies the Department of Mental Health's responsibility for the provision of Mental Health services and states, in part, that the Department of Mental Health "shall be responsible for the provision of mental health services as defined in regulations by the State Department of Mental Health, developed in connection with the State Department of Education, when required in the pupil's individualized education plan."

Additionally, the *Parameters and Guidelines* references Section 5651 of the Welfare and Institutions code which assures, in part, that "the county shall provide the mental health services required by Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code and will comply with all requirement of that chapter."

The California Code of Regulations in Section 60020(i) defines Mental Health services as such: "Mental Health services" means mental health assessments and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code: psychotherapy as defined in Section 2903 of the Business and Professions Code; provided to the pupil individually or in a group, collateral services, ***medication monitoring***, intensive day treatment, day rehabilitation, and case management. "Medication monitoring" is clearly defined in 60020(f) as including all medication support services including prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. The cost of the medications is not a covered service and has not been billed in the SB90 claiming process.

By citing the above code sections that mandate medication monitoring as a service provided under Chapter 26.5, the *Parameters and Guidelines* includes medication monitoring by implication and reference. That this service was not specifically listed in the guidelines was clearly an oversight and indicates that the *Parameters and Guidelines* need to be amended accordingly.

c) **Treatment Costs for Crisis Intervention**

The County does not concur that these are ineligible costs.

It was the intent of AB3632 and later amendments not to include mental health services designed to respond to "psychiatric emergencies or other situations requiring an immediate response" (Article 2, section 60040(e)). This language was related primarily to inpatient hospitalization. The services currently in dispute were not provided as psychiatric emergency services leading to hospitalization or other emergency care, but rather were provided in the normal course of mental health treatment. These services were provided as defined in the California Code of Regulations, Title 9, Section 543, and designed to alleviate problems which, if untreated, presented imminent threat to the pupil.

SCO's Comments

The finding and recommendation for ineligible case management costs for clients placed in out-of-state residential facilities, and treatment costs for medication support and crisis intervention, remain unchanged.

Case management costs incurred for handicapped and disabled students placed in out-of-state schools are an ineligible cost for the Handicapped and Disabled Students Program but are eligible under the Seriously Emotionally Disturbed Pupils: Out-of State Mental Health Services Program. *Parameters and Guidelines* for this program, adopted October 26, 2000, allows claimants to claim costs commencing on January 1, 1997.

Parameters and Guidelines, Section V(B)2, specifies the following treatment services, when required by a child's individualized education program (IEP), are reimbursable: individual therapy; collateral therapy and contacts; group therapy; day treatment; and the mental health portion of residential treatment in excess of the California Department of Social Services' payments for residential placement. Each treatment service above is defined under Title 9, Section 543 of the *California Administrative Code*. Since medication monitoring and crisis intervention were both defined in regulation at the time *Parameters and Guidelines* was adopted and were not included as reimbursable costs, the only reasonable conclusion is that they were intentionally excluded and, therefore, not reimbursable.

FINDING 2— SEP funds inequitably distributed

The county deducted Special Education Pupil (SEP) categorical funds, also known as AB 3632 funds, received from the State on its claim. However, the offsets were made to treatment costs rather than in direct proportion to allowable assessment/case management and treatment costs.

As a result, SEP funds have been reallocated as follows:

	Audit Adjustment		
	FY 1997-98	FY 1998-99	Totals
Assessment costs	$ (270,394)	$ (255,773)	$ (526,167)
Treatment costs	270,394	255,773	526,167
Difference	$ —	$ —	$ —

Recommendation

The county should ensure that SEP funds are properly allocated to assessment and treatment costs.

Auditee's Response

> The County does not concur. Even though this is merely a redistribution, with no dollar difference between the amounts claimed and the amounts allowed, the County does not concur with the SCO auditor's reason for this redistribution. The auditor states that the redistribution was necessary because the net assessment/case management costs are fully reimbursable under this mandate, while net treatment costs are reimbursable at a rate of only 10%. The County believes that **both** assessment/case management and treatment costs are fully reimbursable. As stated in the response to Finding 5 below, this issue is being clarified in budget trailer bill legislation (AB 2781).

SCO's Comments

The narrative portion of this finding has been edited as a result of a legislative change in allowable treatment costs (see Finding 4). However, the fiscal effect of the finding and recommendation remains unchanged.

FINDING 3— Medi-Cal revenue offsets overstated

The county properly offset its claimed costs by the amount of Medi-Cal funding received that was applicable to the mental health treatment services provided. However, since the SCO auditor reduced the amount of allowable treatment costs in Finding 1 above, the county's Medi-Cal revenue offsets are overstated as follows:

	Audit Adjustment		
	FY 1997-98	FY 1998-99	Totals
Treatment costs:			
Medi-Cal offsets claimed	$ 768,403	$ 631,404	$ 1,399,807
Medi-Cal offsets allowed	(671,642)	(539,662)	(1,211,304)
Difference	$ 96,761	$ 91,742	$ 188,503

Recommendation

No recommendation is necessary because the county properly offset Medi-Cal funding received against claimed costs.

Auditee's Response

> The auditor credited back the federal share of Medi-Cal revenue that was received for services found to be ineligible for compensation under this claim. This credit back to the County would be adjusted if any disallowed services are found to be eligible.

SCO's Comments

No adjustment to Medi-Cal revenue offsets is required because no revision has been made to Finding 1.

FINDING 4— Fiscal effect of Assembly Bill 2781 on net treatment costs

For FY 1997-98, the county claimed net mental health treatment costs at a level greater than 10% of allowable net treatment costs reimbursable under this program. A portion of the non-reimbursable costs was funded with realignment (non-categorical) funds. For FY 1998-99, the county claimed 100% of net mental health treatment costs incurred rather than 10% of treatment costs.

Parameters and Guidelines specifies that 10% of mental health treatment costs covered by the State's Short-Doyle Act are reimbursable. Therefore, the SCO auditor computed the required offset to claimed costs as follows:

	Audit Adjustment		
	FY 1997-98	FY 1998-99	Totals
Net treatment costs claimed	$ 6,613,403	$ 7,239,637	$ 13,853,040
Less treatment costs adjusted in Findings 1 through 4 above	(547,927)	(675,923)	(1,223,850)
Allowable net treatment costs	6,065,476	6,563,714	12,629,190
Less reimbursable costs (10%)	(606,548)	(656,371)	(1,262,919)
Non-reimbursable costs (90%)	5,458,928	5,907,343	11,366,271
Non-reimbursable costs claimed	(920,407)	—	(920,407)
(Understated) funding of non-reimbursable costs [1]	$ (4,538,521)	$(5,907,343)	$(10,445,864)

[1] The audit adjustment for understated funding of non-reimbursable costs was increased by $57,975, from $10,387,889 ($4,480,546 for FY 1997-98 and $5,907,343 for FY 1998-99) to $10,445,864 ($4,538,521 for FY 1997-98 and $5,907,343 for FY 1998-99) because of the elimination of the finding relating to claimed unit rates exceeding the maximum rates allowable.

On September 30, 2002, (subsequent to the issuance of the draft report) AB 2781 (Chapter 1167, Statutes of 2002) changed the *Parameters and Guidelines* regulatory criteria. The legislation states that the percentage of treatment costs claimed by counties for FY 2000-01 and prior fiscal years is not subject to dispute by the SCO. Consequently, the SCO applied the percentage of net treatment costs claimed to allowable net

treatment costs. As a result, rather than understating realignment funding by $10,445,864, the county overstated realignment funding by $76,257, a difference of $10,522,121, as follows:

	Audit Adjustment		
	FY 1997-98	FY 1998-99	Total
Calculation to determine allowable net treatment costs:			
Net treatment costs claimed	$ 6,613,403	$ 7,239,637	$ 13,853,040
Less realignment funding claimed	(920,407)	—	(920,407)
Adjusted net treatment costs claimed	$ 5,692,996	$ 7,239,637	$ 12,932,633
Percentage of adjusted net treatment costs claimed	86.08%	100%	
Calculation to determine overstated realignment funding claimed:			
Allowable net treatment costs per audit	$ 6,065,476	$ 6,563,714	$ 12,629,190
Percentage of treatment costs claimed	86.08%	100%	
Reimbursable treatment costs	$ 5,221,326	$ 6,563,714	$ 11,785,040
Less allowable net treatment costs per audit	(6,065,476)	(6,563,714)	(12,629,190)
Realignment funding per audit	$ (844,150)	—	$ (844,150)
Less realignment funding claimed	(920,407)	—	(920,407)
Overstated realignment funding claimed	$ 76,257	$ —	$ 76,257

Recommendation

The county should ensure that only reimbursable treatment costs are claimed in accordance with program guidelines.

Auditee's Response

> The SCO auditor allowed only 10% of treatment costs related to this program, while the County claimed these costs at 100%. Since this issue is being clarified in budget trailer legislation (AB 2781), the County will reserve comment and discussion on this matter pending the outcome of this legislative effort.

SCO's Comments

The above finding has been adjusted to reflect the fiscal effect of AB 2781. AB 2781 reduced realignment funding and, therefore, increased net reimbursable costs by $10,522,121 ($4,614,778 for FY 1998-99 and $5,907,343 for FY 1999-2000).

Schedule 1— Summary of Program Costs July 1, 1997, through June 30, 1999

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustments	Reference [1]
July 1, 1997, through June 30, 1998				
Assessment/case management costs	$ 4,043,451	$ 3,989,022	$ (54,429)	Finding 1
Administrative costs	1,112,862	1,112,862	—	
Offsetting revenues:				
State categorical funds	—	(270,394)	(270,394)	Finding 2
Short-Doyle/Medi-Cal funds	(263,748)	(263,748)	—	
Net assessment/case management costs	4,892,565	4,567,742	(324,823)	
Treatment costs	6,763,081	5,847,999	(915,082)	Finding 1
Administrative costs	1,410,275	1,410,275	—	
Offsetting revenues:				
State categorical funds	(791,550)	(521,156)	270,394	Finding 2
Short-Doyle/Medi-Cal funds	(768,403)	(671,642)	96,761	Finding 3
Net treatment costs	6,613,403	6,065,476	(547,927)	
Realignment funding adjustment	(920,407)	(844,150)	76,257	Finding 4
Net treatment costs after funding adjustment	5,692,996	5,221,326	(471,670)	
Total costs	$10,585,561	9,789,068	$ (796,493)	
Amount paid by the State		(10,585,561)		
Amount paid in excess of allowable costs claimed		$ 796,493		
July 1, 1998, through June 30, 1999				
Assessment/case management costs	$ 3,682,941	$ 3,620,072	$ (62,869)	Finding 1
Administrative costs	1,315,956	1,315,956	—	
Offsetting revenues:				
State categorical funds	—	(255,773)	(255,773)	Finding 2
Short-Doyle/Medi-Cal funds	(317,663)	(317,663)	—	
Net assessment/case management costs	4,681,234	4,362,592	(318,642)	
Treatment costs	6,778,968	5,755,530	(1,023,438)	Finding 1
Administrative costs	1,883,623	1,883,623	—	
Offsetting revenues:				
State categorical funds	(791,550)	(535,777)	255,773	Finding 2
Short-Doyle/Medi-Cal funds	(631,404)	(539,662)	91,742	Finding 3
Net treatment costs	7,239,637	6,563,714	(675,923)	
Total costs	$11,920,871	10,926,306	$ (994,565)	
Amount paid by the State		(11,920,871)		
Amount paid in excess of allowable costs claimed		$ 994,565		

Schedule 1 (continued)

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustments	Reference [1]
Summary: July 1, 1997, through June 30, 1999				
Assessment/case management costs	$ 7,726,392	$ 7,609,094	$ (117,298)	Finding 1
Administrative costs	2,428,818	2,428,818	—	
Offsetting revenues:				
State categorical funds	—	(526,167)	(526,167)	Finding 2
Short-Doyle/Medi-Cal funds	(581,411)	(581,411)	—	
Net assessment/case management costs	9,573,799	8,930,334	(643,465)	
Treatment costs	13,542,049	11,603,529	(1,938,520)	Finding 1
Administrative costs	3,293,898	3,293,898	—	
Offsetting revenues:				
State categorical funds	(1,583,100)	(1,056,933)	526,167	Finding 2
Short-Doyle/Medi-Cal funds	(1,399,807)	(1,211,304)	188,503	Finding 3
Net treatment costs	13,853,040	12,629,190	(1,223,850)	
Realignment funding adjustment	(920,407)	(844,150)	76,257	Finding 4
Net treatment costs after funding adjustment	12,932,633	11,785,050	(1,147,593)	
Total costs	$22,506,432	20,715,374	$(1,791,058)	
Amount paid by the State		(22,506,432)		
Amount paid in excess of allowable costs claimed		$ 1,791,058		

[1] See Schedule 2

Schedule 2— Summary of Audit Adjustments July 1, 1997, through June 30, 1999

	Audit Adjustments [1]				
	Finding 1	Finding 2	Finding 3	Finding 4	Total
July 1, 1997, through June 30, 1998					
Assessment/case management costs	$ (54,429)	$ —	$ —	$ —	$ (54,429)
Offsetting revenues:					
State categorical funds	—	(270,394)	—	—	(270,394)
Net assessment/case management costs	(54,429)	(270,394)	—	—	(324,823)
Treatment costs	(915,082)	—	—	—	(915,082)
Offsetting revenues:					
State categorical funds	—	270,394	—	—	270,394
Short-Doyle/Medi-Cal funds	—	—	96,761	—	96,761
Net treatment costs	(915,082)	270,394	96,761	—	(547,927)
Realignment funding adjustment	—	—	—	76,257	76,257
Net treatment costs after funding adjustment	(915,082)	270,394	96,761	76,257	(471,670)
Total adjustment for FY 1997-98	(969,511)	—	96,761	76,257	(796,493)
July 1, 1998, through June 30, 1999					
Assessment/case management costs	(62,869)	—	—	—	(62,869)
Offsetting revenues:					
State categorical funds	—	(255,773)	—	—	(255,773)
Net assessment/case management costs	(62,869)	(255,773)	—	—	(318,642)
Treatment costs	(1,023,438)	—	—	—	(1,023,438)
Offsetting revenues:					
State categorical funds	—	255,773	—	—	255,773
Short-Doyle/Medi-Cal funds	—	—	91,742	—	91,742
Net treatment costs	(1,023,438)	255,773	91,742	—	(675,923)
Total adjustment for FY 1998-99	(1,086,307)	—	91,742	—	(994,565)
Totals	$ (2,055,818)	$ —	$ 188,503	$ 76,257	$ (1,791,058)

[1] See Findings and Recommendations section.

Attachment—
Auditee's Response to Draft Audit Report

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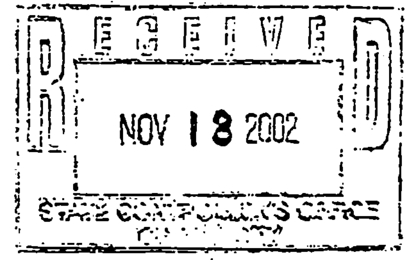
September 25, 2002



State Controller's Office
Division of Audits
P.O. Box 942850
Sacramento, CA 94250-5874

Attn: Jim L. Spano, Chief
Compliance Audits Bureau

We have reviewed the draft report prepared by the State Controller's Office covering their audit of the claims filed by our county for the costs of the legislatively mandated *Handicapped and Disabled Students Program* (Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985), for the period of July 1, 1997 through June 30, 1999.

The County does not concur with the recommendations made in this draft report. However, regarding the recommendation dealing with case management costs for clients placed in out-of-state residential facilities, the County has claimed these expenditures under a separate, newly-identified mandated costs claim. Our responses to the auditor's findings are attached.

Please contact Shaun Skelly at (714) 834-5521 if you have any questions concerning our responses.

David E. Sundstrom
Auditor-Controller

DES:as

Attachment
cc: Doug Barton, Health Care Agency, Behavioral Health Services
Alice Manning, Health Care Agency, Financial & Administrative Services
Shaun Skelly, Auditor-Controller, Agency Accounting
Alice Sworder, Health Care Agency Accounting

RESPONSES TO ORANGE COUNTY AUDIT REPORT HANDICAPPED AND DISABLED STUDENTS PROGRAM

Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985
July 1, 1997 through June 30, 1999

1. FINDING 1 – Ineligible costs claimed

Recommendation: The county should establish procedures to ensure that costs claimed are eligible increased costs incurred as a result of the mandate.

Response:
The County does not concur. We have established procedures to ensure that costs claimed are eligible increased costs incurred as a r⁻sult of the mandate, and we have been following those procedures since we started submitting claims for the *Handicapped and Disabled Students Program*. In the narrative below we have responded to the auditor's findings on (a) case management costs for clients placed in out-of-state residential facilities, (b) treatment costs for medication support, and (c) treatment costs for crisis intervention separately.

a) **Case Management costs for clients placed in out-of-state residential facilities.**
The County concurs that these costs are reimbursable under the *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services Program*, and we have subsequently claimed these costs in the *SED* claim for Fiscal Years 1997-98, 1998-99, 1999-2000, and 2000-01.

However, at the time we filed the *Handicapped and Disabled Students Program* claims for Fiscal Years 1997-98 and 1998-99, which are the years being audited, the *SED Program* had not been identified as a mandated program, and the County believed that these costs were eligible to be claimed as part of the *Handicapped & Disabled Students Program* mandate. Claiming instructions for the *SED Program* were not issued until January 2001.

b) **Treatment Costs for Medication Support.**
The County does not concur that these are ineligible costs.

The *Parameters and Guidelines*, Summary of Mandates, references California Code of Regulations, Division 9, Sections 60000-60200, Title 2, as well as Division 7, Title 1 of the Government Code commencing with Section 7570. The *Parameters and Guidelines* specifically cites Government Code sections 7571 and 7576 <u>and their implementing regulations</u> as governance. The "implementing regulations" for the provision of Chapter 26.6 of the Government Code are found in the California Code of Regulations, Title 2, Division 9, the Joint Regulations for Handicapped Children.

Section 7576 (amended in 1996) of the Government Code identifies the Department of Mental Health's responsibility for the provision of Mental Health services and states, in part, that the Department of Mental Health "shall be responsible for the provision of mental health services as defined in regulations by the State Department of Mental Health, developed in connection with the State Department of Education, when required in the pupil's individualized education plan."

Additionally, the *Parameters and Guidelines* references Section 5651 of the Welfare and Institutions code which assures, in part, that "the county shall provide the mental health services required by Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code and will comply with all requirement of that chapter."

The California Code of Regulations in Section 60020(i) defines Mental Health services as such: "Mental Health services" means mental health assessments and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code; psychotherapy as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, ***medication monitoring***, intensive day treatment, day rehabilitation, and case management. "Medication monitoring" is clearly defined in 60020(f) as including all medication support services including prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. The cost of the medications is not a covered service and has not been billed in the SB90 claiming process.

By citing the above code sections that mandate medication monitoring as a service provided under Chapter 26.5, the *Parameters and Guidelines* includes medication monitoring by implication and reference. That this service was not specifically listed in the guidelines was clearly an oversight and indicates that the *Parameters and Guidelines* need to be amended accordingly.

c) **Treatment Costs for Crisis Intervention**
The County does not concur that these are ineligible costs.

It was the intent of AB3632 and later amendments not to include mental health services designed to respond to "psychiatric emergencies or other situations requiring an immediate response" (Article 2, section 60040(e)). This language was related primarily to inpatient hospitalization. The services currently in dispute were not provided as psychiatric emergency services leading to hospitalization or other emergency care, but rather were provided in the normal course of mental health treatment. These services were provided as defined in the California Code of Regulations, Title 9, Section 543, and designed to alleviate problems which, if untreated, presented imminent threat to the pupil.

<u>2. FINDING 2 – Claimed unit rates exceeded the maximum rates allowable.</u>

<u>Recommendation:</u> The county should ensure that costs claimed are within the maximum rates set by the California Department of Mental Health.

<u>Response:</u> The County does not concur. We believe this finding by the State Controller is misstated in three respects. The first relates to the County's right to reimbursement of the costs of performing the mandated activity. The second relates to an existing interpretation by the Commission on State mandates relating to capitated rates relating to SB 90 programs. The third relates to the State Controller's misrepresentation of the *Parameters and Guidelines* for this program.

1. Article XIIIB, Section 6 of the State Constitution allows for the reimbursement of the <u>costs</u> of state mandates passed down to local agencies:

CALIFORNIA CONSTITUTION
ARTICLE 13B: GOVERNMENT SPENDING LIMITATION

SEC. 6. Whenever the Legislature or any state agency mandates a new program or higher level of service on any local government, the State shall provide a subvention of funds to reimburse such local government for the costs of such program or increased level of service...

2. The Commission on State Mandates has contemplated the issue of capitated rates vs. full-cost rates in their revised parameters and guidelines for the program known as *Prisoner Parental Rights* (Chapter 1376, Statutes of 1976, Welfare and Institutions Code, Sections 366.26 and 300 c, e, f, I and j). The Commission ruled that the mandated costs associated with Article XIIIB, Section 6 of the State Constitution could not be capitated at a statewide level. They ruled that the State was required to reimburse local agencies for the full cost rate, and required local governments to provide additional documentation if they used a rate higher than the average daily jail rate. This situation is identical. The Department of Justice, just like the California Department of Mental Health, annually establishes statewide reimbursement rates, otherwise referred to as statewide maximum allowances (SMAs). These SMAs or capitated rates are applicable to many purposes, but they are not to be applied to state mandated costs covered under Article XIIIB.

3. In the draft audit findings, the State Controller misrepresents what is stated in the *Parameters and Guidelines* by saying, "Parameters and Guidelines states that reimbursable costs are governed by the Short-Doyle/Medi-Cal Program." The *Parameters and Guidelines* refer to the Short-Doyle/Medi-Cal Program in the following contexts:

   - IEP participation is not subject to the Short-Doyle Act (Summary of the Mandate)
   - Provisions of WIC Section 5651, Subdivision (g), result in a higher level of service within the county Short-Doyle program (Summary of the Mandate)
   - Such mental health services are subject to the current cost sharing formula of the Short-Doyle Act (90-10 cost sharing). (Summary of the Mandate)
   - Any mental health treatment required by an IEP is subject to the Short-Doyle cost sharing formula. (Commission on State Mandates' decision)
   - Reimbursable activities not subject to the Short-Doyle Act (IEP costs, et al). (Reimbursable Costs)
   - The scope of the mandate is 100% reimbursement, except that for individuals billed to Medi-Cal only, the Federal Financing Participation portion (FFP) for these activities should be deducted from the reimbursable activities not subject to the Short-Doyle Act. (Reimbursable Costs)
   - Reimbursable activities subject to the Short-Doyle Act, or Mental Health Treatment Services. (Reimbursable Costs)
     - Scope of mandate is 10% reimbursement
     - Provision of mental health services when required by child's IEP are 10% reimbursable: Individual therapy, Collateral therapy and contacts, Group therapy, Day treatment, and Mental Health portion of residential treatment in excess of the Department of Social Services payment for the residential placement.
   - Any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments and Medi-Cal payments), which is received from any source, e.g. federal, state, etc.

Those are the sum total of references to the term "Short-Doyle" in the *Parameters and Guidelines* for this program. At no point is it stated or implied that the Short-Doyle program governs the definition of reimbursable costs as the State Controller notes in the audit finding. Therefore, we do not agree with the conclusions reached by the State Controller in Finding 2.

AUDITOR-CONTROLLER
COUNTY OF ORANGE

HALL OF FINANCE AND RECORDS
12 CIVIC CENTER PLAZA, ROOM 202
POST OFFICE BOX 567
SANTA ANA, CALIFORNIA 92702-0567

(714) 834-2450 FAX: (714) 834-2569

www.oc.ca.gov/ac

JOHN H. NAKANE
CHIEF ASSISTANT AUDITOR-CONTROLLER

JAMES M. McCONNELL
ASSISTANT AUDITOR-CONTROLLER
CENTRAL OPERATIONS

SHAUN M. SKELLY
ASSISTANT AUDITOR-CONTROLLER
AGENCY ACCOUNTING

MAHESH N. PATEL
ASSISTANT AUDITOR-CONTROLLER
INFORMATION TECHNOLOGY

DAVID E. SUNDSTROM, CPA
AUDITOR-CONTROLLER

May 22, 2003

Steve Westly
California State Controller
Division of Accounting and Reporting
P. O. Box 942850
Sacramento, CA 94250

Attn: Ginny Brummels

Re: Handicapped and Disabled Students Claim, Chapter 1747/84
Fiscal Years 1997/98 and 1998/99

This is in response to your letters of April 28, 2003, instructing our office to remit a payment for $796,493 for amounts owed to the State for our county's Fiscal Year 1997/98 claim for the *Handicapped and Disabled Students* mandated cost program, and $994,565 for the Fiscal Year 1998/99 claim. As stated in our letter of February 24, 2003, the County does not concur with the State Controller's audit finding that these costs, which represent medication monitoring and crisis intervention services, are ineligible for reimbursement. Therefore, we will not be remitting payment for these costs, and we do not agree that the State Controller should offset these amounts from the next payments due to our county for State mandated cost programs.

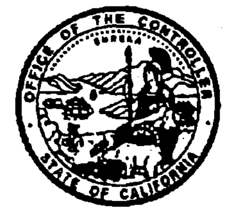
We had previously requested a review of all disputed issues named in your audit report for this program, and we supplied documentation supporting our responses to the audit. Our request for a review was denied. It is therefore our county's intention to file an Incorrect Reduction Claim with the Commission on State Mandates.

Please contact Sandra Fair, Chief of Behavioral Health Operations for the Health Care Agency for the County of Orange, at (714) 834-6032, if you wish further information on the health services being disallowed in your audit. Contact Shaun Skelly of my office at (714) 834-5521 if you have any questions concerning this correspondence.

David E. Sundstrom
Auditor-Controller

DES:as

cc: Jim L. Spano, State Controller's Office, Compliance Audit Bureau
Walter Barnes, Chief Deputy State Controller, Finance
Sandra Fair, Health Care Agency, Behavioral Health Services
Alice Manning, Health Care Agency, Financial & Administrative Services
Shaun Skelly, Auditor-Controller, Agency Accounting
Alice Sworder, Auditor-Controller, Health Care Agency Accounting



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STEVE WESTLY
CALIFORNIA STATE CONTROLLER
DIVISION OF ACCOUNTING AND REPORTING

APRIL 28, 2003

AUDITOR-CONTROLLER
COUNTY OF ORANGE
P O BOX 567
SANTA ANA CA 92702

DEAR CLAIMANT:

RE: HANDI & DISABLE STU CH 1747/84

WE HAVE REVIEWED YOUR 1998/1999 FISCAL YEAR REIMBURSEMENT CLAIM FOR THE MANDATED COST PROGRAM REFERENCED ABOVE. THE RESULTS OF OUR REVIEW ARE AS FOLLOWS:

AMOUNT CLAIMED	11,920,871.00
LESS: TOTAL ADJUSTMENTS (DETAIL ON PAGE 2)	- 994,565.00
CLAIM AMOUNT APPROVED	10,926,306.00
LESS: TOTAL PRIOR PAYMENTS (DETAIL ON PAGE 2)	11,920,871.00
AMOUNT DUE STATE	$ 994,565.00

PLEASE REMIT A WARRANT IN THE AMOUNT OF $ 994,565.00 WITHIN 30 DAYS FROM THE DATE OF THIS LETTER, PAYABLE TO THE STATE CONTROLLER'S OFFICE, DIVISION OF ACCOUNTING AND REPORTING, P.O. BOX 942850, SACRAMENTO, CA 94250-5875 WITH A COPY OF THIS LETTER. FAILURE TO REMIT THE AMOUNT DUE WILL RESULT IN OUR OFFICE PROCEEDING TO OFFSET THE AMOUNT FROM THE NEXT PAYMENTS DUE TO YOUR AGENCY FOR STATE MANDATED COST PROGRAMS.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT FRAN STUART AT (916) 323-0766 OR IN WRITING AT THE ABOVE ADDRESS.

SINCERELY,

Ginny Brummels

GINNY BRUMMELS
MANAGER

LOCAL REIMBURSEMENT SECTION
P.O. BOX 942850 SACRAMENTO, CA 94250-5875

AUDITOR-CONTROLLER
MAY 02 2003

ADJUSTMENT TO CLAIM:		
FIELD AUDIT FINDINGS	- 994,565.00	
LESS: TOTAL ADJUSTMENTS		- 994,565.00
PRIOR PAYMENTS:		
SCHEDULE NO. MA01326A PAID 09-25-2000	0.00	
SCHEDULE NO. MA91376A PAID 03-20-2000	1,920,871.00	
SCHEDULE NO. MA81002E PAID 03-03-1999	10,000,000.00	
LESS: TOTAL PRIOR PAYMENTS		11,920,871.00

STEVE WESTLY
California State Controller
Division of Accounting and Reporting

April 28, 2003

The Honorable David E. Sundstrom
Auditor-Controller, Orange County
12 Civic Center Plaza
Santa Ana, CA 92701

Dear Claimant:

Re: HANDICAPPED & DISABLED STUDENTS CH 1747/84

We have reviewed your 1997/1998 fiscal year reimbursement claim for the mandated cost program referenced above. The results of our review are as follows:

Amount Claimed	$10,585,561.00
Less: Total Adjustments (Detail on Page 2)	-796,493.00
Claim Amount Approved	9,789,068.00
Less: Total Prior Payments (Detail on Page 2)	-10,585,561.00
Amount Due State	$-796,493.00

Please remit a warrant in the amount of $796,493.00 within 30 days from the date of this letter, payable to the State Controller's Office, Division of Accounting and Reporting, P. O. Box 942850, Sacramento, CA 94250-5875 with a copy of this letter. Failure to remit the amount due will result in our office proceeding to offset the amount from the next payments due to your agency for State Mandated Cost Programs. If you have any questions, please contact Fran Stuart at (916) 323-0766 or in writing at the above address.

Sincerely,

Ginny Brummels,
Manager

MAILING ADDRESS P.O. Box 942850, Sacramento, CA 94250
SACRAMENTO 3301 C Street, Suite 500, Sacramento, CA 95816 (916) 445-8717

ADJUSTMENT TO CLAIM

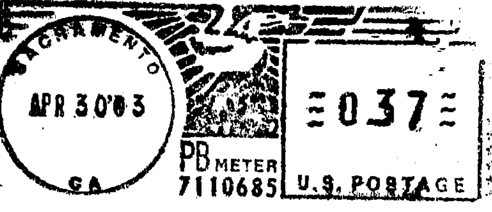
Field Audit Findings	-$796,493.00	
Less: Total Adjustments		-$796,493.00

PRIOR PAYMENTS:

SCHEDULE NO. MA71656E PAID 01/22/1998	$5,213,171.00	
SCHEDULE NO. MA81005A PAID 03/15/1999	$1,698,983.00	
SCHEDULE NO. MA91305A PAID 08/13/1999	$3,662,883.00	
SCHEDULE NO. MA91332A PAID 10/29/1999	$ 10,524.00	
Less: Total Prior Payments		- $10,585,561.00

STEVE WESTLY
CALIFORNIA STATE CONTROLLER

P.O. BOX 942850
SACRAMENTO, CA 94250-0001



MAY 0 2 2003
AUDITOR-CONTROLLER

92701#4057

COUNTY OF ORANGE
HEALTH CARE AGENCY

FINANCIAL AND ADMINISTRATIVE SERVICES

MICHAEL SCHUMACHER
DIRECTOR

DAVID L. RILEY
CHIEF FINANCIAL OFFICER

MAILING ADDRESS:
515 N. SYCAMORE, ROOM 618
SANTA ANA, CA 92701

TELEPHONE: (714) 834-4422
FAX: (714) 834-5506

December 27, 1999

State Controller's Office
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Subject: FY 1998-99 Handicapped & Disabled Students Claim

Attached to the Handicapped & Disabled Students Claim (SB90) is a draft of Orange County's mental health cost report for FY 98-99. At this time, our cost report is in the process of being finalized. After the completion of our cost report, a copy of this version will be sent to your office.

If you have any questions, please call Sheri Vukelich at (714) 834-7591.

Sincerely,

Eliseo Gillamac, Senior Accountant
Behavioral Health Care Accounting

CLAIM FOR PA[illegible]ENT
Pursuant to Government Code Section 17561
SERVICES TO HANDICAPPED STUDENTS

[illegible]or State Controller Use Only
(19) Program Number 00111
(20) Date File ____/____/____
(21) LRS Input ____/____/____

L A B E L H E R E

(01) Claimant Identification Number	Reimbursement Claim Date
(02) Mailing Address	(22) HDS-1, (03)(a)
Claimant Name	(23) HDS-1, (03)(b)
County of Location	(24) HDS-1, (03)(c)
Street Address or P.O. Box	(25) HDS-1, (04)(1)(d)
City / State / Zip Code	(26) HDS-1, (04)(2)(d)

Type of Claim	Estimated Claim	Reimbursement Claim		
	(03) Estimated [X]	(09) Reimbursement [ ]	(27) HDS-1, (04)(3)(d)	
	(04) Combined [ ]	(10) Combined [ ]	(28) HDS-1, (04)(4)(d)	
	(05) Amended [ ]	(11) Amended [X]	(29) HDS-1, (04)(5)(d)	
			(30) HDS-1, (06)	
Fiscal Year of Cost	(06) 19 99 /2000	(12) 19 98 /19 99	(31) HDS-3, (05)	317,663
Total Claimed Amount	(07) 10,000,000	(13) 11,920,871	(32) HDS-3, (06)	0
Less: 10% Late Penalty, not to exceed $1,000		(14)	(33) HDS-3, (07)	0
Less: Estimated Claim Payment Received		(15) 10,000,000	(34)	
Net Claimed Amount		(16) 1,920,871	(35)	
Due From State	(08) 10,000,000	(17) 1,920,871	(36)	
Due to State	State	(18)	(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 set forth on the attached statements.

Signature of Authorized Representative: [signature]

Date: 12/27/99

Eliseo Gillamac
Type or Print Name

Senior Accountant/Auditor
Title

(39) Name of Contact Person for Claim: Sheri Vukelich, Accountant/Auditor

Telephone Number: (714) 834-7591 Ext. ______

State Controller's Office

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SERVICES TO HANDICAPPED STUDENTS

For State Controller Use Only
(19) Program Number 00111
(20) Date File ____/____/____
(21) LRS Input ____/____/____

LABEL HERE

(01) Claimant Identification Number	Reimbursement Claim Date
(02) Mailing Address	(22) HDS-1, (03)(a)
Claimant Name	(23) HDS-1, (03)(b)
County of Location	(24) HDS-1, (03)(c)
Street Address or P.O. Box	(25) HDS-1, (04)(1)(d)
City State Zip Code	(26) HDS-1, (04)(2)(d)

Type of Claim	Estimated Claim	Reimbursement Claim		
	(03) Estimated [X]	(09) Reimbursement [ ]	(27) HDS-1, (04)(3)(d)	
	(04) Combined [ ]	(10) Combined [ ]	(28) HDS-1, (04)(4)(d)	
	(05) Amended [ ]	(11) Amended [X]	(29) HDS-1, (04)(5)(d)	
			(30) HDS-1, (06)	
Fiscal Year of Cost	(06) 19 99 /2000	(12) 19 98 /19 99	(31) HDS-3, (05)	From A2 317,663
Total Claimed Amount	(07) 10,000	(13) From A2 11,920,871	(32) HDS-3, (06)	0
Less: 10% Late Penalty, not to exceed $1,000		(14)	(33) HDS-3, (07)	0
Less: Estimated Claim Payment Received		(15) 10,000,000	(34)	
Net Claimed Amount		(16) 1,920,871	(35)	
Due From State	(08)	(17) 1,920,871	(36)	
Due to State		(18)	(37)	

(38) CERTIFICATION OF CLAIM
In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 set forth on the attached statements.

Signature of Authorized Representative ______________________ Date ______________________

Eliseo Gillamac — Type or Print Name
Senior Accountant/Auditor — Title

(39) Name of Contact Person for Claim: Sheri Vukelich, Accountant/Auditor
Telephone Number: (714) 834-7591 Ext. ________

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY	FORM HDS-3

(01) Claimant County of Orange/Health Care Agency	(02) Type of Claims Reimbursement [X] Estimated [ ]	Fiscal Year 1998/1999

(03) **Reimbursable Components**	
Assessment of Individuals With Exceptional Needs	
(a) Assessment: Interviews, Review of Records, Observations, Testing, etc. From A3	3,682,941
(b) Residential Placement: IEP Reviews, Case Management, and Expanded IEP	
(c) Related Services: Attendance at IEP meetings, Meeting with IEP Members and Parents, and Review of Independent Assessment.	
(d) Due Process Proceedings	
(e) Administrative Costs From A5	1,315,956
Mental Health Treatment	
(f) Treatment Services: Short-Doyle Program From A4.1	6,778,968
(g) Administrative Costs From A5.1	1,883,623
(04) Sub-total for Assessment of Individual with Exceptional Needs [Sum of (03), lines (a) to (e)]	4,998,897
(05) Less: Amount Received from Short-Doyle / Medi-Cal (FFP only) From G2	317,663
(06) Less: Amount Received from State Categorical Funding	
(07) Less: Amount Received from Other (Patient Fees)	
(08) Total for Assessment of Individual with Exceptional Needs [Line (04) minus the sum of lines (05) to (07)	4,681,234
(09) Sub-Total for Mental Health Treatment [block (03), lines (f) and (g)]	8,662,591
(10) Less: Non-Categorical State General / Realignment Funds	
(11) Less: Amount Received from State Categorical Funds From F1	699,001
(12) Less: Amount Received from Short-Doyle / Medi-Cal (FFP only) From G2	631,404
(13) Less: Amount Received from Other (SAMSHA Grant, Patient Fees) From J3	92,549
(14) Total Mental health Treatment [Line (09) minus the sum of lines (10) to (13)]	7,239,637
(15) Total Claimed Amount [Sum of line (08) and line (14)]	11,920,871

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1998-99

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

[X] Assessment

[ ] Treatment Services

[ ] Residential Placement

[ ] Other (identify)

(04) Description of Expenses: Complete columns (a) through (f). From B1

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
East County - Santa Ana	3006	15/01	209,491	1.1600	243,010
East County - Santa Ana	3006	15/30	230,945	1.4900	344,108
West County - Westminster	3009	15/01	245,996	1.2700	312,415
West County - Westminster	3009	15/30	205,057	1.6300	334,243
CGC Inc. - Fullerton	3051	15/01	42,164	1.0337	43,585
CGC Inc. - Fullerton	3051	15/30	58,332	1.3310	77,640
South County - Laguna	8002	15/01	509,194	0.6900	351,344
South County - Laguna	8002	15/30	632,923	0.8800	556,972
CGC Inc. - Santa Ana	8034	15/01	63,347	1.0337	65,482
CGC Inc. - Santa Ana	8034	15/30	106,989	1.3310	142,402
Western Youth - Garden Grove	8035	15/01	75,103	1.1496	86,338
Western Youth - Garden Grove	8035	15/30	100,484	1.1496	115,516
Western Youth - Laguna	8056	15/01	64,051	1.1496	73,633
Western Youth - Laguna	8056	15/30	280,123	1.1496	322,029
Western Youth - Anaheim	8061	15/01	6,528	1.1496	7,505
Western Youth - Anaheim	8061	15/30	30,261	1.1496	34,788
North County - Placentia	8067	15/01	170,800	1.0700	182,756
North County - Placentia	8067	15/30	276,638	1.3800	381,760
Latino Psych Center	30AE	15/01	1,203	1.4324	1,723
Latino Psych Center	30AE	15/30	3,097	1.8380	5,692
TOTAL ASSESSMENT			3,308,426		

(05) Total	Subtotal	Page: 1 of 1	3,682,941

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1998-99

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

☐ Assessment
☒ Treatment Services
☐ Residential Placement
☐ Other (identify)

(04) Description of Expenses: Complete columns (a) through (f). From 32

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
East County - Santa Ana	3006	15/10	116,558	1.4900	173,671
East County - Santa Ana	3006	15/40	286,730	1.4900	427,228
East County - Santa Ana	3006	15/50	18,875	1.4900	28,124
East County - Santa Ana	3006	15/60	48,891	2.7800	135,917
East County - Santa Ana	3006	15/70	3,673	2.2400	8,228
West County - Westminster	3009	15/10	123,518	1.6300	201,334
West County - Westminster	3009	15/40	399,514	1.6300	651,208
West County - Westminster	3009	15/50	180	1.6300	293
West County - Westminster	3009	15/60	66,169	3.0200	199,830
West County - Westminster	3009	15/70	8,229	2.4300	19,996
CGC Inc. - Fullerton	3051	15/10	99,891	1.3265	132,505
CGC Inc. - Fullerton	3051	15/40	187,119	1.3310	249,055
CGC Inc. - Fullerton	3051	15/50	87,042	1.3310	115,853
CGC Inc. - Fullerton	3051	15/60	10,280	2.2270	22,894
CGC Inc. - Fullerton	3051	15/70	3,420	2.4683	8,442
Sounty County - Laguna	8002	15/10	565,539	0.8800	497,674
Sounty County - Laguna	8002	15/40	1,021,061	0.8800	898,534
Sounty County - Laguna	8002	15/50	125,679	0.8800	110,598
Sounty County - Laguna	8002	15/60	144,887	1.6400	237,615
Sounty County - Laguna	8002	15/70	10,645	1.3200	14,051
Aspen Health Services	8079	15/10	18	2.7703	50
Aspen Health Services	8079	15/40	203	2.7703	562
Latino Psych Center	30AE	15/10	4,047	1.8380	7,438
Latino Psych Center	30AE	15/40	4,044	1.8380	7,433
Latino Psych Center	30AE	15/50	1,035	1.8380	1,902
Latino Psych Center	30AE	15/60	140	3.4164	478
			3,337,387		

(05) Total Subtotal X Page: 1 of 2 — 4,150,913

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1998-99

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

☐ Assessment
☒ Treatment Services
☐ Residential Placement
☐ Other (identify)

(04) Description of Expenses: Complete columns (a) through (f). From 62

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
CGC Inc. - Santa Ana	8034	15/10	93,534	1.3265	124,073
CGC Inc. - Santa Ana	8034	15/40	171,414	1.3310	228,152
CGC Inc. - Santa Ana	8034	15/50	6,376	1.3310	8,486
CGC Inc. - Santa Ana	8034	15/60	14,169	2.2270	31,554
CGC Inc. - Santa Ana	8034	15/70	2,288	2.4683	5,647
Western Youth - Garden Grove	8035	15/10	194,136	1.1496	223,179
Western Youth - Garden Grove	8035	15/40	380,490	1.1496	437,411
Western Youth - Garden Grove	8035	15/50	6,012	1.1496	6,911
Western Youth - Garden Grove	8035	15/60	30,405	1.1496	34,954
Western Youth - Garden Grove	8035	15/70	2,324	1.1496	2,672
Western Youth - Laguna	8056	15/10	118,215	1.1496	135,900
Western Youth - Laguna	8056	15/40	251,799	1.1496	289,468
Western Youth - Laguna	8056	15/50	78,256	1.1496	89,963
Western Youth - Laguna	8056	15/60	20,194	1.1496	23,215
Western Youth - Laguna	8056	15/70	328	1.1496	377
Western Youth - Anaheim	8090	15/10	3,441	1.1496	3,956
Western Youth - Anaheim	8090	15/40	9,052	1.1496	10,406
Western Youth - Anaheim	8090	15/50	-	1.1496	-
Western Youth - Anaheim	8090	15/60	1,020	1.1496	1,173
Western Youth - Anaheim	8090	15/70	-	1.1496	0
North County - Placentia	8067	15/10	168,506	1.3800	232,538
North County - Placentia	8067	15/40	331,708	1.3800	457,757
North County - Placentia	8067	15/50	2,803	1.3800	3,868
North County - Placentia	8067	15/60	105,198	2.5600	269,307
North County - Placentia	8067	15/70	3,424	2.0700	7,088
Page Total			1,995,092		2,628,055
Grand Total			5,332,479		

(05) Total X	Subtotal	Page: 2 of 2	6,778,968

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-6

(01) Claimant	(02) Fiscal Year Costs Were Incurred
County of Orange Health Care Agency	FY 1998-99

(03) Reimbursable Components: Administrative Costs

[X] Assessment of Individuals [ ] Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).

(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
			Object Accounts			
Administrative Cost (See Attached Schedule)			From fis 1,315,956			
Totals			1,315,956	0	0	0

(05) Total Direct Costs		1,315,956
Indirect Costs		
(06) Indirect Cost Rate	[From ICRP]	0.00%
(07) Total Indirect Costs	[Line (06) x line (04)(d)] or [Line (06) x { (04)(d) + (04)(e) }]	
(08) Total Direct and Indirect Costs	[Line (05) + line (07)]	1,315,956

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-6

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1998-99

(03) Reimbursable Components: Administrative Costs

[ ] Assessment of Individuals [X] Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).

(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	Object Accounts (d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Administrative Cost (See Attached Schedule)			From A/S 1,883,623			
Totals			1,883,623	0	0	0

(05) Total Direct Costs		1,883,623
Indirect Costs		
(06) Indirect Cost Rate	[From ICRP]	0.00%
(07) Total Indirect Costs	[Line (06) x line (04)(d)] or [Line (06) x { (04)(d) + (04)(e) }]	
(08) Total Direct and Indirect Costs	[Line (05) + line (07)]	1,883,623

SB 90 Handicapped & Disabled Students Claim
Allocation of Administration applied to claim
FY 98/99

	Administration	% of Admin. Applied to Mode 15	Mode 15 Administration	SEP/AB 3632 % Assmnt	SEP/AB 3632 % Trtmt	SEP/AB 3632 Administration Assmnt	SEP/AB 3632 Administration Trtmt
Non-M/C Administration (1)	8,369,902	92.39%	7,732,952	10.20%	14.60%	788,761	1,129,011
M/C Administration (2)	5,382,812	96.02%	5,168,576	10.20%	14.60%	527,195	754,612
Total	13,752,714		12,901,528			1,315,956	1,883,623

Notes:
Allocation of administration to mode 15 based on total labor charges (salaries and wages).
(1) Non/Medi-Cal administration allocated to all modes of services. (2) Medi-Cal administration allocated to the modes of services which generate Medi-Cal.
(3) Mode 15 administration allocated to AB 3632 program based on units of service.

State Controller's Office

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SERVICES TO HANDICAPPED STUDENTS

State Controller Use Only	
(19) Program Number 00111	
(20) Date File	___/___/___
(21) LRS Input	___/___/___

LABEL HERE

(01) Claimant Identification Number	
(02) Mailing Address	
Claimant Name	
County of Location	
Street Address or P.O. Box	
City / State / Zip Code	

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated [X]	(09) Reimbursement [ ]
	(04) Combined [ ]	(10) Combined [ ]
	(05) Amended [ ]	(11) Amended [ ] X
Fiscal Year of Cost	(06) 19 98 /19 99	(12) 19 97 /19 98
Total Claimed Amount	(07) 10,000,000	(13) 10,585,561
Less: 10% Late Penalty, not to exceed $1,000		(14)
Less: Estimated Claim Payment Received		(15) 5,213,171
Net Claimed Amount		(16) 5,372,390
Due From State	(08) 10,000,000	(17) 5,372,390
Due to State		(18)

Reimbursement Claim Date	
(22) HDS-1, (03)(a)	
(23) HDS-1, (03)(b)	
(24) HDS-1, (03)(c)	
(25) HDS-1, (04)(1)(d)	
(26) HDS-1, (04)(2)(d)	
(27) HDS-1, (04)(3)(d)	
(28) HDS-1, (04)(4)(d)	
(29) HDS-1, (04)(5)(d)	
(30) HDS-1, (06)	
(31) HDS-3, (05)	263,748
(32) HDS-3, (06)	0
(33) HDS-3, (07)	0
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 set forth on the attached statements.

Signature of Authorized Representative: Dawn Nelson

Date: 12-24-98

Dawn Nelson
Type or Print Name

Senior Accountant/Auditor
Title

(39) Name of Contact Person for Claim: Sheri Vukelich, Accountant/Auditor

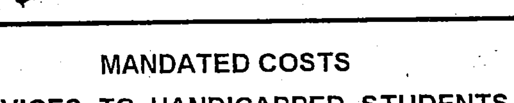
Telephone Number: (714) 834-7591 Ext. ______

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
CLAIM SUMMARY

FORM HDS-3

(01) Claimant County of Orange/Health Care Agency	(02) Type of Claims Reimbursement [X] Estimated [ ]	Fiscal Year 1997/1998

(03) Reimbursable Components	
Assessment of Individuals With Exceptional Needs	
(a) Assessment: Interviews, Review of Records, Observations, Testing, etc.	4,043,451
(b) Residential Placement: IEP Reviews, Case Management, and Expanded IEP	
(c) Related Services: Attendance at IEP meetings, Meeting with IEP Members and Parents, and Review of Independent Assessment.	
(d) Due Process Proceedings	
(e) Administrative Costs	1,112,862
Mental Health Treatment	
(f) Treatment Services: Short-Doyle Program	6,763,081
(g) Administrative Costs	1,410,275
(04) Sub-total for Assessment of Individual with Exceptional Needs [Sum of (03), lines (a) to (e)]	5,156,313
(05) Less: Amount Received from Short-Doyle / Medi-Cal (FFP only)	263,748
(06) Less: Amount Received from State Categorical Funding	
(07) Less: Amount Received from Other (Patient Fees)	
(08) Total for Assessment of Individual with Exceptional Needs [Line (04) minus the sum of lines (05) to (07)	4,892,565
(09) Sub-Total for Mental Health Treatment [block (03), lines (f) and (g)]	8,173,356
(10) Less: Non-Categorical State General / Realignment Funds	920,407
(11) Less: Amount Received from State Categorical Funds	699,001
(12) Less: Amount Received from Short-Doyle / Medi-Cal (FFP only)	768,403
(13) Less: Amount Received from Other (SAMSHA Grant, Patient Fees)	92,549
(14) Total Mental health Treatment [Line (09) minus the sum of lines (10) to (13)]	5,692,996
(15) Total Claimed Amount [Sum of line (08) and line (14)]	10,585,561



MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1997-98

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

- [X] Assessment
- [ ] Treatment Services
- [ ] Residential Placement
- [ ] Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
East County - Santa Ana	3006	15/01	74,532	1.7100	127,450
East County - Santa Ana	3006	15/30	146,964	2.1900	321,851
West County - Westminster	3009	15/01	121,237	1.3700	166,095
West County - Westminster	3009	15/30	141,760	1.7500	248,080
CGC Inc. - Fullerton	3051	15/01	17,683	1.2909	22,827
CGC Inc. - Fullerton	3051	15/30	112,952	1.5255	172,308
South County - Laguna	8002	15/01	217,148	1.3500	293,150
South County - Laguna	8002	15/30	875,932	1.7300	1,515,362
CGC Inc. - Santa Ana	8034	15/01	28,139	1.2909	36,325
CGC Inc. - Santa Ana	8034	15/30	64,492	1.5255	98,383
Western Youth - Garden Grove	8035	15/01	58,162	1.2081	70,266
Western Youth - Garden Grove	8035	15/30	160,647	1.2031	193,274
Western Youth - Laguna	8056	15/01	44,917	1.2081	54,264
Western Youth - Laguna	8056	15/30	196,658	1.2031	236,599
Western Youth - Westmont	8061	15/01	5,980	1.2081	7,224
Western Youth - Westmont	8061	15/30	11,063	1.2031	13,310
North County - Placentia	8067	15/01	102,282	1.3200	135,012
North County - Placentia	8067	15/30	196,255	1.6900	331,671
TOTAL ASSESSMENT			2,576,803		

(05) Total	Subtotal	Page: 1 of 1	4,043,451

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1997-98

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

☐ Assessment
☒ Treatment Services
☐ Residential Placement
☐ Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
East County - Santa Ana	3006	15/10	65,431	2.1900	143,294
East County - Santa Ana	3006	15/40	172,341	2.1900	377,427
East County - Santa Ana	3006	15/50	810	2.1900	1,774
East County - Santa Ana	3006	15/60	25,666	4.0800	104,717
East County - Santa Ana	3006	15/70	2,711	3.2900	8,919
West County - Westminster	3009	15/10	85,916	1.7500	150,353
West County - Westminster	3009	15/40	352,503	1.7500	616,880
West County - Westminster	3009	15/50	2,346	1.7500	4,106
West County - Westminster	3009	15/60	54,636	3.2500	177,567
West County - Westminster	3009	15/70	5,214	2.6200	13,661
CGC Inc. - Fullerton	3051	15/10	111,088	1.5255	169,465
CGC Inc. - Fullerton	3051	15/40	219,760	1.5255	335,244
CGC Inc. - Fullerton	3051	15/50	54,715	1.5255	83,468
CGC Inc. - Fullerton	3051	15/60	9,275	2.4156	22,405
CGC Inc. - Fullerton	3051	15/70	3,148	2.5859	8,140
Sounty County - Laguna	8002	15/10	436,049	1.7300	754,365
Sounty County - Laguna	8002	15/40	539,572	1.7300	933,460
Sounty County - Laguna	8002	15/50	122,239	1.7300	211,473
Sounty County - Laguna	8002	15/60	90,941	3.2200	292,830
Sounty County - Laguna	8002	15/70	7,671	2.6000	19,945
			2,362,032		

(05) Total	Subtotal X	Page: 1 of 2	4,429,493

Chapters 1747/84 and 1274/85

New 3/97

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1997-98

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

☐ Assessment
☒ Treatment Services
☐ Residential Placement
☐ Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
CGC Inc. - Santa Ana	8034	15/10	107,053	1.5255	163,309
CGC Inc. - Santa Ana	8034	15/40	156,544	1.5255	238,808
CGC Inc. - Santa Ana	8034	15/50	7,614	1.5255	11,615
CGC Inc. - Santa Ana	8034	15/60	15,934	2.4156	38,490
CGC Inc. - Santa Ana	8034	15/70	1,364	2.5859	3,527
Western Youth - Garden Grove	8035	15/10	171,829	1.2031	206,727
Western Youth - Garden Grove	8035	15/40	342,955	1.2031	412,609
Western Youth - Garden Grove	8035	15/50	13,586	1.2031	16,345
Western Youth - Garden Grove	8035	15/60	25,511	1.2242	31,231
Western Youth - Garden Grove	8035	15/70	1,855	1.2232	2,269
Western Youth - Laguna	8056	15/10	97,532	1.2031	117,341
Western Youth - Laguna	8056	15/40	137,339	1.2031	165,233
Western Youth - Laguna	8056	15/50	67,964	1.2031	81,767
Western Youth - Laguna	8056	15/60	7,490	1.2242	9,169
Western Youth - Laguna	8056	15/70	1,917	1.2232	2,345
Western Youth - Westmont	8061	15/10	13,687	1.2031	16,467
Western Youth - Westmont	8061	15/40	26,932	1.2031	32,402
Western Youth - Westmont	8061	15/50	-	1.2031	-
Western Youth - Westmont	8061	15/60	3,061	1.2242	3,747
Western Youth - Westmont	8061	15/70	567	1.2232	694
North County - Placentia	8067	15/10	150,012	1.6900	253,520
North County - Placentia	8067	15/40	207,424	1.6900	350,547
North County - Placentia	8067	15/50	-	-	-
North County - Placentia	8067	15/60	54,264	3.1400	170,389
North County - Placentia	8067	15/70	1,991	2.5300	5,037
Page Total			1,614,425		2,333,588
Grand Total			3,976,457		

(05) Total X	Subtotal	Page: 2 of 2	6,763,081

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS COMPONENT / ACTIVITY COST DETAIL	Form HDS-5

(01) Claimant County of Orange Health Care Agency			(02) Fiscal Year Costs Were Incurred FY 1997-98			
(03) Reimbursable Components: Due Process Proceedings						
(04) Description of Expenses: Complete columns (a) through (g).			Object Accounts			
(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Totals			0	0	0	0
(05) Total Direct Costs						0
Indirect Costs						
(06) Indirect Cost Rate	[From ICRP]					0.00%
(07) Total Indirect Costs	[Line (06) x line (05)(d)] or [Line (06) x { (05)(d) + (05)(e) }]					
(08) Total Direct and Indirect Costs	[Line (05) + line (07)]					0

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-6

(01) Claimant: County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred: FY 1997-98

(03) Reimbursable Components: Administrative Costs

[X] Assessment of Individuals [ ] Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).

(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	Object Accounts (d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Administrative Cost (See Attached Schedule)			1,112,862			
Totals			1,112,862	0	0	0

(05) Total Direct Costs		1,112,862
Indirect Costs		
(06) Indirect Cost Rate	[From ICRP]	0.00%
(07) Total Indirect Costs	[Line (06) x line (04)(d)] or [Line (06) x { (04)(d) + (04)(e) }]	
(08) Total Direct and Indirect Costs	[Line (05) + line (07)]	1,112,862

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS COMPONENT / ACTIVITY COST DETAIL	Form HDS-6

(01) Claimant: County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred: FY 1997-98

(03) Reimbursable Components: Administrative Costs

[ ] Assessment of Individuals [X] Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).

(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	Object Accounts (d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Administrative Cost (See Attached Schedule)			1,410,275			
Totals			1,410,275	0	0	0

(05) Total Direct Costs		1,410,275
Indirect Costs		
(06) Indirect Cost Rate	[From ICRP]	0.00%
(07) Total Indirect Costs	[Line (06) x line (04)(d)] or [Line (06) x { (04)(d) + (04)(e) }]	
(08) Total Direct and Indirect Costs	[Line (05) + line (07)]	1,410,275

Chapters 1747/84 and 1274/85 New 3/97

SB 90 Handicapped & Disabled Students Claim
Allocation of Administration applied to claim
FY 97/98

	From J6 Administration	From A6 % of Admin. Applied to Mode 15	Mode 15 Administration	From A6 SEP/AB 3632 % Assmnt	Trtmt	SEP/AB 3632 Administration Assmnt	Trtmt
Non-M/C Administration (1)	7,976,880	90.67%	7,232,637	9.13%	11.57%	660,340	836,816
M/C Administration (2)	5,190,525	95.49%	4,956,432	9.13%	11.57%	452,522	573,458
Total	13,167,405		12,189,069			1,112,862	1,410,275

Notes:
Allocation of administration to mode 15 based on total labor charges (salaries and wages).
(1) Non/Medi-Cal administration allocated to all modes of services. (2) Medi-Cal administration allocated to the modes of services which generate Medi-Cal.
(3) Mode 15 administration allocated to AB 3632 program based on units of service.

OFFICE OF THE STATE CONTROLLER

STATE MANDATED COSTS CLAIMING INSTRUCTIONS NO. 2006-03

HANDICAPPED AND DISABLED STUDENTS II

February 17, 2006

In accordance with Government Code (GC) section 17561, eligible claimants may submit claims to the State Controller's Office (SCO) for reimbursement of costs incurred for state mandated cost programs. The following are claiming instructions and forms that eligible claimants will use for filing claims for the Handicapped and Disabled Students II (HDS II) program. These claiming instructions are issued subsequent to adoption of the program's Parameters and Guidelines (P's & G's) by the Commission on State Mandates (COSM).

On May 26, 2005, the COSM determined that GC sections 7572.55 and 7576, as added and amended in 1994 and 1996, and the joint regulations adopted by the Departments of Mental Health and Education as emergency regulations in 1998 and final regulations in 1999 (Cal. Code Regs., tit. 2, §§ 60000 et seq.), established costs mandated by the State according to the provisions listed in the P's & G's. For your reference, the P's & G's are included as an integral part of the claiming instructions.

Eligible Claimants

Any city, county, or city and county that incurs increased costs as a result of this mandate, is eligible to claim reimbursement of these costs.

Filing Deadlines

A. Reimbursement Claims

Initial reimbursement claims must be filed within 120 days from the issuance date of claiming instructions. Costs incurred for this program, are eligible for reimbursement for fiscal years 2001-02 to 2004-05. Claims for fiscal years 2001-02 to 2004-05 must be filed with the SCO and be delivered or postmarked on or before **June 19, 2006**. Actual reimbursement claims for fiscal year 2005-06 and estimated claims for fiscal year 2006-07 must be filed on or before **January 16, 2007**.

In order for a claim to be considered properly filed, it must include any specific supporting documentation requested in the instructions. **Claims filed more than one year after the deadline or without the requested supporting documentation will not be accepted.**

B. Late Penalty

1. Initial Claims

AB 3000, enacted into law on September 30, 2002, amended the late penalty assessments on initial claims. Late initial claims submitted **on or after September 30, 2002,** are assessed a late penalty of 10% of the total amount of the initial claims **without limitation.**

2. Annual Reimbursement Claims

All late annual reimbursement claims are assessed a late penalty of 10% subject to the $1,000 limitation regardless of when the claims were filed.

C. Estimated Claims

Unless otherwise specified in the claiming instructions local agencies are not required to provide cost schedules and supporting documents with an estimated claim if the estimated amount does not exceed the previous fiscal year's actual costs by more than 10%. Claimants can simply enter the estimated amount on form FAM-27, line (07).

However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, claimants must complete supplemental claim forms to support their estimated costs as specified for the program to explain the reason for the increased costs. If no explanation supporting the higher estimate is provided with the claim, it will automatically be adjusted to 110% of the previous fiscal year's actual costs. Future estimated claims filed with the SCO must be postmarked by January 15 of the fiscal year in which costs will be incurred. Claims filed timely will be paid before late claims.

Minimum Claim Cost

GC section 17564(a) provides that no claim shall be filed pursuant to Sections 17551 and 17561, unless such claim exceeds one thousand dollars ($1,000).

Reimbursement of Claims

To be eligible for mandated cost reimbursement for any fiscal year, only actual costs may be claimed. Actual costs are those costs actually incurred to implement the mandated activities. Actual costs must be traceable and supported by source documents that show the validity of such costs, when they were incurred, and their relationship to the reimbursable activities. A source document is a document created at or near the same time the actual cost was incurred for the event or activity in question.

Source documents may include, but are not limited to, employee time records or time logs, sign-in sheets, invoices, and receipts. Evidence corroborating the source documents may include, but is not limited to, worksheets, cost allocation reports (system generated), purchase orders, contracts, agendas, training packets, and declarations. Evidence corroborating the source documents may include data relevant to the reimbursable activities otherwise in compliance with local, state, and federal government requirements. However, corroborating documents cannot be substituted for source documents.

Certification of Claim

In accordance with the provisions of GC section 17561, an authorized representative of the claimant shall be required to provide a certification of claim stating: "I certify, (or declare), under penalty of perjury under the laws of the State of California that the foregoing is true and correct," and must further comply with the requirements of the Code of Civil Procedure section 2015.5, for those costs mandated by the State and contained herein.

Audit of Costs

All claims submitted to the SCO are reviewed to determine if costs are related to the mandate, are reasonable and not excessive, and the claim was prepared in accordance with the SCO's claiming instructions and the P's & G's adopted by the COSM. If any adjustments are made to a claim, a "Notice of Claim Adjustment" specifying the claim component adjusted, the amount adjusted, and the reason for the adjustment, will be mailed within 30 days after payment of the claim.

Pursuant to GC section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency pursuant to this chapter is subject to the initiation of an audit by the SCO no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the SCO to initiate an audit shall commence to run from the date of initial payment of the claim.

In any case, an audit shall be completed no later than two years after the date that the audit is commenced. All documents used to support the reimbursable activities must be retained during the period subject to audit. If an audit has been initiated by the SCO during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings. On-site audits will be conducted by the SCO as deemed necessary.

Retention of Claiming Instructions

The claiming instructions and forms in this package should be retained permanently in your Mandated Cost Manual for future reference and use in filing claims. These forms should be duplicated to meet your filing requirements. You will be notified of updated forms or changes to claiming instructions as necessary.

Questions, or requests for hard copies of these instructions, should be faxed to Angie Lowi-Teng at (916) 323-6527 or e-mailed to **LRSDAR@sco.ca.gov.** Or, if you wish, you may call the Local Reimbursements Section at (916) 324-5729.

For your reference, these and future mandated costs claiming instructions and forms can be found on the Internet at **www.sco.ca.gov/ard/local/locreim/index.shtml.**

Address for Filing Claims

Claims should be rounded to the nearest dollar. Submit a signed original and a copy of form FAM-27, Claim for Payment, and all other forms and supporting documents. **(To expedite the payment process, please sign the form in blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)**

Use the following mailing addresses:

If delivered by U.S. Postal Service:	If delivered by other delivery services:
Office of the State Controller Attn: Local Reimbursements Section Division of Accounting and Reporting P.O. Box 942850 Sacramento, CA 94250	Office of the State Controller Attn: Local Reimbursements Section Division of Accounting and Reporting 3301 C Street, Suite 500 Sacramento, CA 95816

Adopted: December 9, 2005

PARAMETERS AND GUIDELINES

Government Code Sections 7572.55 and 7576
Statutes 1994, Chapter 1128, Statutes 1996, Chapter 654

California Code of Regulations, Title 2, Sections 60000 et seq.
(emergency regulations effective July 1, 1998 [Register 98, No. 26],
final regulations effective August 9, 1999 [Register 99, No. 33])

Handicapped and Disabled Students II (02-TC-40/02-TC-49)

Counties of Stanislaus and Los Angeles, Claimants

I. SUMMARY OF THE MANDATE

On May 26, 2005, the Commission on State Mandates (Commission) adopted its Statement of Decision in *Handicapped and Disabled Students II*, finding that Government Code sections 7572.55 and 7576, as added or amended in 1994 and 1996, and the joint regulations adopted by the Departments of Mental Health and Education as emergency regulations in 1998 and final regulations in 1999 (Cal. Code Regs., tit. 2, §§ 60000 et seq.), impose a reimbursable state-mandated program on counties within the meaning of article XIII B, section 6 of the California Constitution and Government Code section 17514.

The Handicapped and Disabled Students program was initially enacted in 1984 and 1985 as the state's response to federal legislation (Individuals with Disabilities Education Act, or IDEA) that guaranteed to disabled pupils, including those with mental health needs, the right to receive a free and appropriate public education. Three other Statements of Decision have been adopted by the Commission on the Handicapped and Disabled Students program. They include *Handicapped and Disabled Students* (CSM 4282), *Reconsideration of Handicapped and Disabled Students* (04-RL-4282-10), and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05).

Eligible claimants are ***not*** entitled to reimbursement under these parameters and guidelines for the activities approved by the Commission in *Handicapped and Disabled Students* (CSM 4282), *Reconsideration of Handicapped and Disabled Students* (04-RL-4282-10), and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05).

These parameters and guidelines address only the amendments to the Handicapped and Disabled Students program. The Commission found, pursuant to the court's ruling in *Hayes v. Commission on State Mandates* (1992) 11 Cal. App.4th 1564, that Government Code sections 7572.55 and 7576, as added or amended in 1994 and 1996, and the joint regulations adopted by the Departments of Mental Health and Education as emergency regulations in 1998 and final regulations in 1999, constitute a reimbursable state-mandated program since the state "freely chose" to impose the costs upon counties as a means of implementing the federal IDEA program.

II. ELIGIBLE CLAIMANTS

Any county, or city and county, that incurs increased costs as a result of this reimbursable state-mandated program is eligible to claim reimbursement of those costs.

III. PERIOD OF REIMBURSEMENT

Government Code section 17557 states that a test claim shall be submitted on or before June 30 following a given fiscal year to establish eligibility for reimbursement for that fiscal year. The test claim for this mandate was filed by the County of Stanislaus (02-TC-40) on June 27, 2003, and filed by the County of Los Angeles (02-TC-49) on June 30, 2003. Therefore, the period of reimbursement begins July 1, 2001.

Actual costs for one fiscal year shall be included in each claim. Estimated costs for the subsequent year may be included on the same claim, if applicable. Pursuant to Government Code section 17561, subdivision (d)(1)(A), all claims for reimbursement of initial fiscal year costs shall be submitted to the State Controller within 120 days of the issuance date for the claiming instructions.

If the total costs for a given year do not exceed $1,000, no reimbursement shall be allowed, except as otherwise allowed by Government Code section 17564.

IV. REIMBURSABLE ACTIVITIES

To be eligible for mandated cost reimbursement for any given fiscal year, only actual costs may be claimed. Actual costs are those costs actually incurred to implement the mandated activities. Actual costs must be traceable and supported by source documents that show the validity of such costs, when they were incurred, and their relationship to the reimbursable activities. A source document is a document created at or near the same time the actual cost was incurred for the event or activity in question. Source documents may include, but are not limited to, employee time records or time logs, sign-in sheets, invoices, and receipts.

Evidence corroborating the source documents may include, but is not limited to, worksheets, cost allocation reports (system generated), purchase orders, contracts, agendas, calendars, and declarations. Declarations must include a certification or declaration stating, "I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct," and must further comply with the requirements of Code of Civil Procedure section 2015.5. Evidence corroborating the source documents may include data relevant to the reimbursable activities otherwise reported in compliance with local, state, and federal government requirements. However, corroborating documents cannot be substituted for source documents.

The claimant is only allowed to claim and be reimbursed for increased costs for reimbursable activities identified below. Claims should *exclude* reimbursable costs included in claims previously filed, beginning in fiscal year 2001-2002, for the Handicapped and Disabled Students program (CSM 4282).[1] Increased cost is limited to the cost of an activity that the claimant is required to incur as a result of the mandate.

[1] Some costs disallowed by the State Controller's Office in prior years are now reimbursable beginning July 1, 2001 (e.g., medication monitoring). Rather than claimants re-filing claims for

For each eligible claimant, the following activities are eligible for reimbursement:

A. Interagency Agreements (Cal. Code Regs., tit. 2, § 60030)

The one-time activity of revising the interagency agreement with each local educational agency to include the following eight procedures:

1) Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code section 7575, subdivision (f). For purposes of this subdivision only, the term "appropriate" means any service identified in the pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(2).)

2) A host county to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)

3) Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)

4) At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)

5) The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)

6) The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)

7) The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)

8) Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)

(The activities of updating or renewing the interagency agreements are not reimbursable.)

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those costs incurred beginning July 1, 2001, the State Controller's Office will reissue the audit reports.

B. Referral and Mental Health Assessments (Gov. Code, § 7576; Cal. Code Regs., tit. 2, §§ 60040, 60045)

1) Work collaboratively with the local educational agency to ensure that assessments performed prior to referral are as useful as possible to the community mental health service in determining the need for mental health services and the level of services needed. (Gov. Code, § 7576, subd. (b)(1).)

2) A county that receives a referral for a pupil with a different county of origin shall forward the referral within one working day to the county of origin. (Gov. Code, § 7576, subd. (g); Cal. Code Regs., tit. 2, § 60040, subd. (g).)

3) If the county determines that a mental health assessment is not necessary, the county shall document the reasons and notify the parents and the local educational agency of the county determination within one day. (Cal Code Regs., tit. 2, § 60045, subd. (a)(1).)

4) If the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral. (Cal. Code Regs., tit. 2, § 60045, subd. (a)(2).)

5) Notify the local educational agency when an assessment is determined necessary. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)

6) Provide the assessment plan to the parent. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)

7) Report back to the referring local educational agency or IEP team within 30 days from the date of the receipt of the referral if no parental consent for a mental health assessment has been obtained. (Cal. Code Regs., tit. 2, § 60045, subd. (c).)

8) Notify the local educational agency within one working day after receipt of the parent's written consent for the mental health assessment to establish the date of the IEP meeting. (Cal. Code Regs., tit. 2, § 60045, subd. (d).)

9) Provide the parent with written notification that the parent may require the assessor to attend the IEP meeting to discuss the recommendation when the parent disagrees with the assessor's mental health service recommendation. (Cal. Code Regs., tit. 2, § 60045, subd. (f).)

10) The county of origin shall prepare yearly IEP reassessments to determine the needs of a pupil. (Cal. Code Regs., tit. 2, § 60045, subd. (h).)

C. Transfers and Interim Placements (Cal. Code Regs., tit. 2, § 60055)

1) Following a pupil's transfer to a new school district, the county shall provide interim mental health services, as specified in the existing IEP, for thirty days, unless the parent agrees otherwise.

2) Participate as a member of the IEP team of a transfer pupil to review the interim services and make a determination of services.

D. Participate as a Member of the Expanded IEP Team When Residential Placement of a Pupil is Recommended (Gov. Code, § 7572.55; Cal Code Regs., tit. 2, § 60100)

1) When a recommendation is made that a child be placed in an out-of-state residential facility, the expanded IEP team, with the county as a participant, shall develop a plan for using less restrictive alternatives and in-state alternatives as soon as they become available, unless it is in the best educational interest of the child to remain in the out-of-state school. (Gov. Code, § 7572.55, subd. (c).)

2) The expanded IEP team, with the county as a participant, shall document the alternatives to residential placement that were considered and the reasons why they were rejected. (Cal. Code Regs., tit. 2, § 60100, subd. (c).)

3) The expanded IEP team, with the county as a participant, shall ensure that placement is in accordance with the admission criteria of the facility. (Cal. Code Regs., tit. 2, § 60100, subd. (j).)

4) When the expanded IEP team determines that it is necessary to place a pupil who is seriously emotionally disturbed in residential care, counties shall ensure that: (1) the mental health services are specified in the IEP in accordance with federal law, and (2) the mental health services are provided by qualified mental health professionals. (Cal. Code Regs., tit. 2, § 60100, subd. (i).)

E. Case Management Duties for Pupils Placed in Residential Care (Cal. Code Regs., tit. 2, §§ 60100, 60110)

1) Coordinate the residential placement plan of a pupil with a disability who is seriously emotionally disturbed as soon as possible after the decision has been made to place the pupil in residential placement. The residential placement plan shall include provisions, as determined in the pupil's IEP, for the care, supervision, mental health treatment, psychotropic medication monitoring, if required, and education of the pupil. (Cal. Code Regs., tit, 2, § 60110, subd, (b)(1).)

2) When the IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a community treatment facility, the lead case manager shall ensure that placement is in accordance with admission, continuing stay, and discharge criteria of the community treatment facility. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(3).)

3) Identify, in consultation with the IEP team's administrative designée, a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost-effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment. (Cal. Code Regs, tit. 2, §§ 60100, subd. (e), 60110, subd. (c)(2).)

4) Document the determination that no nearby placement alternative that is able to implement the IEP can be identified and seek an appropriate placement that is as close to the parents' home as possible. (Cal. Code Regs., tit. 2, § 60100, subd. (f).)

5) Notify the local educational agency that the placement has been arranged and coordinate the transportation of the pupil to the facility if needed. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(7).)

6) Facilitate placement authorization from the county's interagency placement committee pursuant to Welfare and Institutions Code section 4094.5, subdivision (e)(1), by presenting the case of a pupil with a disability who is seriously emotionally disturbed prior to placement in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(11).)

7) Evaluate every 90 days the continuing stay criteria, as defined in Welfare and Institutions Code section 4094, of a pupil placed in a community treatment facility every 90 days. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(8).)

8) Schedule and attend the next expanded IEP team meeting with the expanded IEP team's administrative designee within six months of the residential placement of a pupil with a disability who is seriously emotionally disturbed and every six months thereafter as the pupil remains in residential placement. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(10).)

F. Authorize Payments to Out-Of-Home Residential Care Providers (Cal. Code Regs., tit. 2, § 60200, subd. (e))

1) Authorize payments to residential facilities based on rates established by the Department of Social Services in accordance with Welfare and Institutions Code sections 18350 and 18356. This activity requires counties to determine that the residential placement meets all the criteria established in Welfare and Institutions Code sections 18350 through 18356 before authorizing payment.

G. Provide Psychotherapy or Other Mental Health Treatment Services (Cal. Code Regs., tit. 2, §§ 60020, subd. (i), 60050, subd. (b), 60200, subd. (c))

1) The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)

2) The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)

3) Provide case management services to a pupil when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

4) Provide individual or group psychotherapy services, as defined in Business and Professions Code section 2903, when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

5) Provide medication monitoring services when required by the pupil's IEP. "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication

support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subds. (f) and (i).)

6) Notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of a service, or when the pupil is no longer participating in treatment. ((Cal. Code Regs., tit. 2, § 60050, subd. (b).)

(When providing psychotherapy or other mental health treatment services, the activities of mental health assessments, collateral services, intensive day treatment, case management, crisis intervention, vocational services, and socialization services are not reimbursable.)

V. CLAIM PREPARATION AND SUBMISSION

Each of the following cost elements must be identified for each reimbursable activity identified in section IV. of this document. Each claimed reimbursable cost must be supported by source documentation as described in section IV. Additionally, each reimbursement claim must be filed in a timely manner.

A. Direct Cost Reporting

Direct costs are those costs incurred specifically for the reimbursable activities. The following direct costs are eligible for reimbursement.

1. Salaries and Benefits

Report each employee implementing the reimbursable activities by name, job classification, and productive hourly rate (total wages and related benefits divided by productive hours). Describe the specific reimbursable activities performed and the hours devoted to each reimbursable activity performed.

2. Materials and Supplies

Report the cost of materials and supplies that have been consumed or expended for the purpose of the reimbursable activities. Purchases shall be claimed at the actual price after deducting discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged on an appropriate and recognized method of costing, consistently applied.

3. Contracted Services

Report the name of the contractor and services performed to implement the reimbursable activities. If the contractor bills for time and materials, report the number of hours spent on the activities and all costs charged. If the contract is a fixed price, report the services that were performed during the period covered by the reimbursement claim. If the contract services are also used for purposes other than the reimbursable activities, only the pro-rata portion of the services used to implement the reimbursable activities can be claimed. Submit contract consultant and invoices with the claim and a description of the contract scope of services.

4. Fixed Assets and Equipment

Report the purchase price paid for fixed assets and equipment (including computers) necessary to implement the reimbursable activities. The purchase price includes taxes, delivery costs, and installation costs. If the fixed asset or equipment is also used for purposes other than the reimbursable activities, only the pro-rata portion of the purchase price used to implement the reimbursable activities can be claimed.

B. Indirect Cost Rates

Indirect costs are costs that are incurred for a common or joint purpose, benefiting more than one program, and are not directly assignable to a particular department or program without efforts disproportionate to the result achieved. Indirect costs may include (1) the overhead costs of the unit performing the mandate; and (2) the costs of the central government services distributed to the other departments based on a systematic and rational basis through a cost allocation plan.

Compensation for indirect costs is eligible for reimbursement utilizing the procedure provided in the Office of Management and Budget (OMB) Circular A-87. Claimants have the option of using 10% of labor, excluding fringe benefits, or preparing an Indirect Cost Rate Proposal (ICRP) if the indirect cost rate claimed exceeds 10%.

If the claimant chooses to prepare an ICRP, both the direct costs (as defined and described in OMB Circular A-87 Attachments A and B) and the indirect costs shall exclude capital expenditures and unallowable costs (as defined and described in OMB A-87 Attachments A and B). However, unallowable costs must be included in the direct costs if they represent activities to which indirect costs are properly allocable.

The distribution base may be (1) total direct costs (excluding capital expenditures and other distorting items, such as pass-through funds, major subcontracts, etc.), (2) direct salaries and wages, or (3) another base which results in an equitable distribution.

In calculating an ICRP, the claimant shall have the choice of one of the following methodologies:

1. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) classifying a department's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate which is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected; or
2. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) separating a department into groups, such as divisions or sections, and then classifying the division's or section's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate that is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected.

VI. RECORDS RETENTION

Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district pursuant to this chapter[2] is subject to the initiation of an audit by the State Controller no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the Controller to initiate an audit shall commence to run from the date of initial payment of the claim. All documents used to support the reimbursable activities, as described in Section IV, must be retained during the period subject to audit. If an audit has been initiated by the Controller during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings.

VII. OFFSETTING SAVINGS AND REIMBURSEMENTS

Any offsetting savings the claimant experiences in the same program as a result of the same statutes or executive orders found to contain the mandate shall be deducted from the costs claimed. In addition, reimbursement for this mandate received from any of the following sources shall be identified and deducted from this claim:

1. Funds received by a county pursuant to Government Code section 7576.5.
2. Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes the appropriation made by the Legislature in the Budget Act of 2001, which appropriated funds to counties in the amounts of $12,334,000 (Stats. 2001, ch. 106, items 4440-131-0001), and the $69 million appropriations in 2003 and 2004 (Stats. 2003, ch. 157, item 6110-161-0890, provision 17; Stats. 2004, ch. 208, item 6110-161-0890, provision 10).
3. Private insurance proceeds obtained with the consent of a parent for purposes of this program.
4. Medi-Cal proceeds obtained from the state or federal government that pay for a portion of the county services provided to a pupil under the Handicapped and Disabled Students program in accordance with federal law.
5. Any other reimbursement received from the federal or state government, or other non-local source.

Beginning July 1, 2001, realignment funds under the Bronzan-McCorquodale Act that are used by a county for this program are not required to be deducted from the costs claimed. (Stats. 2004, ch. 493, § 6 (SB 1895).)

VIII. STATE CONTROLLER'S CLAIMING INSTRUCTIONS

Pursuant to Government Code section 17558, subdivision (b), the Controller shall issue claiming instructions for each mandate that requires state reimbursement not later than 60 days after receiving the adopted parameters and guidelines from the Commission, to assist local agencies and school districts in claiming costs to be reimbursed. The claiming instructions shall be derived from the statute or executive order creating the mandate and the parameters and guidelines adopted by the Commission.

[2] This refers to Title 2, division 4, part 7, chapter 4 of the Government Code.

Pursuant to Government Code section 17561, subdivision (d)(l), issuance of the claiming instructions shall constitute a notice of the right of the local agencies and school districts to file reimbursement claims, based upon parameters and guidelines adopted by the Commission.

IX. REMEDIES BEFORE THE COMMISSION

Upon request of a local agency or school district, the Commission shall review the claiming instructions issued by the State Controller or any other authorized state agency for reimbursement of mandated costs pursuant to Government Code section 17571. If the Commission determines that the claiming instructions do not conform to the parameters and guidelines, the Commission shall direct the Controller to modify the claiming instructions to conform to the parameters and guidelines as directed by the Commission.

In addition, requests may be made to amend parameters and guidelines pursuant to Government Code section 17557, subdivision (a), and the California Code of Regulations, title 2, section 1183.2.

X. LEGAL AND FACTUAL BASIS FOR THE PARAMETERS AND GUIDELINES

The Statement of Decision is legally binding on all parties and provides the legal and factual basis for the parameters and guidelines. The support for the legal and factual findings is found in the administrative record for the test claim. The administrative record, including the Statement of Decision, is on file with the Commission.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
HANDICAPPED AND DISABLED STUDENTS II

For State Controller Use Only	Program
(19) Program Number 00263	**263**
(20) Date Filed ___/___/___	
(21) LRS Input ___/___/___	

LABEL HERE

			Reimbursement Claim Data	
(01) Claimant Identification Number				
(02) Claimant Name			(22) HDS -1, (04)(A)(1)(f)	
County of Location			(23) HDS -1, (04)(B)(1)(f)	
Street Address or P.O. Box	Suite		(24) HDS -1, (04)(C)(1)(f)	
City	State	Zip Code	(25) HDS -1, (04)(D)(1)(f)	
Type of Claim	Estimated Claim	Reimbursement Claim	(26) HDS -1, (04)(E)(1)(f)	
	(03) Estimated ☐	(09) Reimbursement ☐	(27) HDS -1, (04)(F)(1)(f)	
	(04) Combined ☐	(10) Combined ☐	(28) HDS -1, (04)(G)(1)(f)	
	(05) Amended ☐	(11) Amended ☐	(29) HDS -1, (06)	
Fiscal Year of Cost	(06) ___/___	(12) ___/___	(30) HDS -1, (07)	
Total Claimed Amount	(07)	(13)	(31) HDS -1, (09)	
Less: 10% Late Penalty		(14)	(32) HDS -1, (10)	
Less: Prior Claim Payment Received		(15)	(33)	
Net Claimed Amount		(16)	(34)	
Due from State	(08)	(17)	(35)	
Due to State		(18)	(36)	

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code Section 17561, I certify that I am the officer authorized by the local agency to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1098, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein, and such costs are for a new program or increased level of services of an existing program. All offsetting savings and reimbursements set forth in the Parameters and Guidelines are identified, and all costs claimed are supported by source documentation currently maintained by the claimant.

The amounts for this Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Authorized Officer ________ Date ________

Type or Print Name ________ Title ________

(38) Name of Contact Person for Claim ________ Telephone Number ( ) - Ext.

E-Mail Address ________

Program 263	HANDICAPPED AND DISABLED STUDENTS II Certification Claim Form Instructions	FORM FAM-27

(01) Enter the payee number assigned by the State Controller's Office.

(02) Enter your Official Name, County of Location, Street or P. O. Box address, City, State, and Zip Code.

(03) If filing an estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing a combined estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended estimated claim, enter an "X" in the box on line (05) Amended.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of the estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form HDS-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing a combined reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended reimbursement claim, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 and supporting schedules for each fiscal year.

(13) Enter the amount of the reimbursement claim from form HDS-1, line (11). The total claimed amount must exceed $1,000.

(14) Claims for fiscal years 2001-02 to 2004-05 must be filed with the SCO and be delivered or postmarked on or before **June 19, 2006.** Actual reimbursement claims for fiscal year 2005-06 and estimated claims for fiscal year 2006-07 must be filed on or before **January 16, 2007**, or the claims shall be reduced by a late penalty. Enter zero if the claim was timely filed, otherwise, enter the product of multiplying line (13) by the factor (0.10% penalty).

(15) If filing an actual reimbursement claim and an estimated claim was previously filed for the same fiscal year, enter the amount received for the claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14), and line (15), from line (13).

(17) If line (16), Net Claimed Amount, is positive, enter that amount on line (17), Due from State.

(18) If line (16), Net Claimed Amount, is negative, enter that amount on line (18), Due to State.

(19) to (21) Leave blank.

(22) to (36) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (36) for the reimbursement claim, e.g. HDS-1, (04)(A)(f), means the information is located on form HDS-1, block (04), line (A), column (f). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, i.e., no cents. Indirect costs percentage should be shown as a whole number and without the percent symbol, i.e., 35.19% should be shown as 35. **Completion of this data block will expedite the payment process.**

(37) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the district's authorized officer, and must include the person's name and title, typed or printed. **Claims cannot be paid unless accompanied by an original signed certification. (To expedite the payment process, please sign the form FAM-27 with blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)**

(38) Enter the name, telephone number, and e-mail address of the person to contact if additional information is required.

Claims should be rounded to the nearest dollar. Submit a signed original and a copy of form FAM-27, Claim for Payment, and all other forms and supporting documents. Use the following mailing addresses:

Address, if delivered by U.S. Postal Service:	***Address, if delivered by other delivery service:***
OFFICE OF THE STATE CONTROLLER **ATTN: Local Reimbursements Section** **Division of Accounting and Reporting** **P.O. Box 942850** **Sacramento, CA 94250**	**OFFICE OF THE STATE CONTROLLER** **ATTN: Local Reimbursements Section** **Division of Accounting and Reporting** **3301 C Street, Suite 500** **Sacramento, CA 95816**

Program 263	MANDATED COSTS HANDICAPPED AND DISABLED STUDENTS II CLAIM SUMMARY					FORM HDS-1
(01) Claimant			(02) Reimbursement ☐ Estimated ☐	Type of Claim		Fiscal Year __ / __
Claim Statistics						
(03) Number of student referrals during the fiscal year of claim						
Direct Costs	**Object Accounts**					
(04) Reimbursable Activities	(a) Salaries	(b) Benefits	(c) Materials and Supplies	(d) Contracted Services	(e) Fixed Assets	(f) Total
A. Interagency Agreements						
B. Referral and Mental Health Assessments						
C. Transfers and Interim Placements						
D. Membership Participation of Expanded IEP Team						
E. Case Management Duties for Pupils						
F. Payment Authorization to Care Providers						
G. Psychotherapy or Other Treatment Services						
(05) Total Direct Costs						
Indirect Costs						
(06) Indirect Cost Rate	[10% or ICRP from 2 CFR, Chapter II, formerly OMB A-87]					%
(07) Total Indirect Costs	[Line (06) x line (05)(a)] or [Line (06) x {line (05)(a) + line (05)(b)}]					
(08) Total Direct and Indirect Costs	[Line (05)(f) + line (07)]					
Cost Reduction						
(09) Less: Offsetting Savings						
(10) Less: Other Reimbursements						
(11) Total Claimed Amount	[Line (08) - {line (09) + line (10)}]					

Program 263	HANDICAPPED AND DISABLED STUDENTS II CLAIM SUMMARY Instructions	FORM HDS-1

(01) Enter the name of the claimant. If more than one department has incurred costs for this mandate, give the name of each department. A form HDS-1 should be completed for each department.

(02) Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year of costs.

Form HDS-1 must be filed for a reimbursement claim. Do not complete form HDS-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form HDS-1 must be completed and a statement attached explaining the increased costs. Without this information the estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Enter the number of students who were referred during the fiscal year of claim.

(04) For each reimbursable activity, enter the total from form HDS-2, line (05), columns (d) through (i) to form HDS-1, block (04), columns (a) through (f) in the appropriate row. Total each row.

(05) Total columns (a) through (f).

(06) Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have its own ICRP for the program.

(07) Multiply Total Salaries, line (05)(a), by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (05)(a), and Total Benefits, line (05)(b), by the Indirect Cost Rate, line (06).

(08) Enter the sum of Total Direct Costs, line (05)(f), and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings. If applicable, enter the total savings experienced by the claimant as a result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements. If applicable, enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, that reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. From Total Direct and Indirect Costs, line (08), subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

Program 263

MANDATED COSTS
HANDICAPPED AND DISABLED STUDENTS II
ACTIVITY COST DETAIL

FORM HDS-2

(01) Claimant	(02) Fiscal Year

(03) Reimbursable Activities: Check only one box per form to identify the activity being claimed.

- ☐ Interagency Agreements
- ☐ Case Management Duties for Pupils
- ☐ Referral and Mental Health Assessments
- ☐ Payment Authorization to Care Providers
- ☐ Transfers and Interim Placements
- ☐ Psychotherapy or Other Treatment Services
- ☐ Member Participation of Extended IEP Team

(04) Description of Expenses			Object Accounts				
(a) Employee Names, Job Classifications, Functions Performed and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Materials and Supplies	(g) Contracted Services	(h) Fixed Assets
(05) Total ☐ Subtotal ☐ Page: ___of___							

Program 263

HANDICAPPED AND DISABLED STUDENTS II
COMPONENT/ACTIVITY COST DETAIL
Instructions

FORM HDS-2

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred.

(03) Check the box which indicates the activity being claimed. Check only one box per form. A separate form HDS-2 shall be prepared for each applicable activity.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, and contracted services expenses. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than three years after the date the claim was filed or last amended, whichever is later. If no funds were appropriated and no payment was made at the time the claim was filed, the time for the Controller to initiate an audit shall be from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub-object Accounts	Columns								Submit supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	
Salaries	Employee Name/Title	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked					
Benefits	Activities Performed	Benefit Rate			Benefits = Benefit Rate x Salaries				
Materials and Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost= Unit Cost X Quantity Used			
Contracted Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service				Itemized Cost of Services Performed		Copy of Contract and Invoice
Fixed Assets	Description of Equipment Purchased	Unit Cost	Usage					Cost= Unit Cost x Usage	

(05) Total line (04), columns (d) through (h) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the activity costs, number each page. Enter totals from line (05), columns (d) through (h) to form HDS-1, block (04), columns (a) through (e) in the appropriate row.

1. INCORRECT REDUCTION CLAIM TITLE

Handicapped and Disabled Students Program

2. CLAIMANT INFORMATION

Orange County
Name of Local Agency or School District

Mark A. Refowitz
Claimant Contact

Behavioral Health Director
Title

405 W. 5th Street
Street Address

Santa Ana, CA, 92701
City, State, Zip

714-834-6032
Telephone Number

714-834-5506
Fax Number

MRefowitz@ochca.com
E-Mail Address

3. CLAIMANT REPRESENTATIVE INFORMATION

Claimant designates the following person to act as its sole representative in this incorrect reduction claim. All correspondence and communications regarding this claim shall be forwarded to this representative. Any change in representation must be authorized by the claimant in writing, and sent to the Commission on State Mandates.

Howard Thomas
Claimant Representative Name

Manager, HCA Claims and Financial Reporting
Title

Orange County, Auditor-Controller
Organization

515 N. Sycamore St., 5th floor
Street Address

Santa Ana, CA, 92701
City, State, Zip

714-834-7407
Telephone Number

714-834-5143
Fax Number

hthomas@ochca.com
E-Mail Address

For CSM Use Only

Filing Date: RECEIVED MAR 15 2010 COMMISSION ON STATE MANDATES

IRC #: 09-4282-I-04

4. IDENTIFICATION OF STATUTES OR EXECUTIVE ORDERS

Please specify the subject statute or executive order that claimaint alleges is not being fully reimbursed pursuant to the adopted parameters and guidelines.

Statutes 1984, Chapter 1747
Statutes 1985, Chapter 1274

5. AMOUNT OF INCORRECT REDUCTION

Please specify the fiscal year and amount of reduction. More than one fiscal year may be claimed.

Fiscal Year	Amount of Reduction
00/01	$1,046,844.00
TOTAL:	

6. NOTICE OF INTENT TO CONSOLIDATE

Please check the box below if there is intent to consolidate this claim.

☐ **Yes, this claim is being filed with the intent to consolidate on behalf of other claimants.**

Sections 7 through 11 are attached as follows:

7. Written Detailed Narrative: pages 1 to 13.

8. Documentary Evidence and Declarations: Exhibit n/a.

9. Claiming Instructions: Exhibit A.

10. Final State Audit Report or Other Written Notice of Adjustment: Exhibit B.

11. Reimbursement Claims: Exhibit C.

(Revised June 2007)

COUNTY OF ORANGE
HANDICAPPED AND DISABLED STUDENTS PROGRAM
Chapters 1747 of 1984 and 1274 of 1985
July 1, 2000 through June 30, 2001

Detailed Narrative

The State Controller's Office (SCO) incorrectly reduced the Handicapped and Disabled Students Claim for Orange County filed for fiscal year 2000/01 (attachment A). The reduction was for $1,046,844 in medication monitoring costs (attachment B). The SCO identified these costs as ineligible in the audit report.

The Parameters and Guidelines (attachment C) state:

"The provisions of Welfare and Institutions Code Section 5651, subdivision (g), result in a higher level of service within the County Short-Doyle Program because the mental health services, pursuant to government code sections 7571 and 7576 and their implementing regulations, must be included in the county Short-Doyle annual plan."

Section 7576 (attachment D) of the Government Code identifies the Department of Mental Health's responsibility for the provision of Mental Health services and states, in part, that the Department of Mental Health "shall be responsible for the provision of mental health services **as defined in regulations** (emphasis added) by the State Department of Mental Health, developed in connection with the State Department of Education, when required in the pupil's individualized education plan."

The definition of Mental Health Services is found in the California Code of Regulations, Section 60020(i) (attachment E). It should also be noted that the Parameters and Guidelines also reference California Code of Regulations, Division 9, Sections 60000-60200.

The California Code of Regulations in Section 60020(i) defined Mental Health services as such: *"Mental health services" means mental health assessments and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code: psychotherapy as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services,* ***medication monitoring*** *(emphasis added), intensive day treatment, day rehabilitation, and case management. These services shall be provided directly or by contract at the discretion of the community mental health service of the county of origin.*

It is clear from the above references that the mandate resulted in a higher level of service which included medication monitoring. Per the Commission on State Mandate's Guidebook: "When the Governor or Legislature mandate a new program or higher level of service upon local agencies and school districts, the state Constitution requires the state to reimburse local agencies and school districts for the cost of these new programs or higher levels of service." A reduction in the reimbursement for a cost incurred as the result of a state mandate is in violation of the State

Constitution (article XIII B, section 6). Therefore the county is seeking to recover the incorrectly reduced amount of $1,046,844.

Timeliness of filing

The audit report was issued on March 30, 2007 the County has 3 years to respond.

Pending claims

The County has a pending Incorrect Reduction Claim with the Commission for identical findings taken in fiscal years 1997 through 1999. The County requests that this claim be included with the existing claim to expedite the process for all involved as the arguments are identical.

FINDING 3— Understated assessment and treatment costs

The claimed costs were not based on actual costs to implement the mandated program. The county used preliminary unit reports to prepare its claims. The county produced the unit reports while the cost report reconciliation was in process. These amounts remained uncorrected once the finalization of the cost reports was complete. In some cases, the county applied an incorrect cost per unit to determine costs. The county also included ineligible medication monitoring services (FY 2000-01 only), crisis intervention, and therapeutic behavioral services. Audit adjustments reflect the changes due to the adoption of the Handicapped and Disabled Students II Program.

We determined allowable costs based on actual units of eligible services, using the appropriate unit cost representing the actual cost to the county. Our calculation resulted in an overstatement of $2,821,410 and an understatement of $3,780,634 for FY 2000-01 and FY 2001-02, respectively.

Parameters and Guidelines for the program specifies that only actual increased costs incurred in the performance of the mandated activities and adequately documented are reimbursable.

Parameters and Guidelines specifies that only the following treatment services are reimbursable: individual therapy, collateral therapy and contacts, group therapy, day treatment, and the mental health portion of residential treatment in excess of California Department of Social Services payments for residential placement.

On December 9, 2005, the COSM adopted the *Parameters and Guidelines* for the Handicapped and Disabled Students II Program. Under this program, medication support is a reimbursable cost. The reimbursement period for the program begins FY 2001-02; therefore, the audit adjustments below do not include medication support costs for FY 2001-02.

Because the county claimed costs that are not based on actual units and costs per unit and claimed ineligible services, it misstated its claims as follows.

	Fiscal Year		
	2000-01	2001-02	Total
Assessment	$ (530,803)	$ 1,613,947	$ 1,083,144
Treatment	(2,290,607)	2,166,687	(123,920)
Audit adjustment	$ (2,821,410)	$ 3,780,634	$ 959,224

Recommendation

We recommend that the county implement policies and procedures to ensure that it utilizes the actual unit-of-service cost per unit and claims only eligible services in accordance with the mandated program.

County's Response

The county did not respond to this finding.

SCO's Comment

The finding remains unchanged.

Attachment A

COUNTY OF ORANGE
SUMMARY OF AB 3632 TREATMENT COSTS
FY 2000 - 2001

TREATMENT

PROVIDER NAME	PROVIDER #	SFC CODE	UNITS	RATE	TOTAL	MC Units	51.36% FFP	42.11% EPSDT
EAST COUNTY - SANTA ANA	3006	15/10	81,475	$1.30	$105,918	12,883	$8,602	$7,053
EAST COUNTY - SANTA ANA	3006	15/40	353,151	$1.25	$441,439	48,170	$30,925	$25,355
EAST COUNTY - SANTA ANA	3006	15/50	-	$1.25	$0	-	$0	$0
EAST COUNTY - SANTA ANA	3006	15/60	55,780	$2.68	$149,490	12,762	$17,566	$14,403
EAST COUNTY - SANTA ANA	3006	15/70	4,322	$1.87	$8,082	1,256	$1,206	$989
SOUTH COUNTY - COSTA MESA	3008	15/10	142,657	$1.30	$185,454	28,507	$19,034	$15,606
SOUTH COUNTY - COSTA MESA	3008	15/40	362,282	$1.25	$452,853	66,354	$42,599	$34,927
SOUTH COUNTY - COSTA MESA	3008	15/50	9,786	$1.25	$12,233	-	$0	$0
SOUTH COUNTY - COSTA MESA	3008	15/60	49,330	$2.68	$132,204	9,751	$13,422	$11,004
SOUTH COUNTY - COSTA MESA	3008	15/70	1,914	$1.87	$3,579	1,439	$1,382	$1,133
WEST COUNTY - WESTMINSTER	3009	15/10	120,138	$1.30	$156,179	21,246	$14,186	$11,631
WEST COUNTY - WESTMINSTER	3009	15/40	394,193	$1.25	$492,741	77,422	$49,705	$40,753
WEST COUNTY - WESTMINSTER	3009	15/50	36,187	$1.25	$45,234	5,680	$3,647	$2,990
WEST COUNTY - WESTMINSTER	3009	15/60	71,477	$2.68	$191,558	17,654	$24,300	$19,923
WEST COUNTY - WESTMINSTER	3009	15/70	6,716	$1.87	$12,559	2,215	$2,127	$1,744
CGC INC - FULLERTON	3051	15/10	64,737	$1.37	$88,690	17,993	$12,660	$10,380
CGC INC - FULLERTON	3051	15/40	109,168	$1.37	$149,560	24,948	$17,554	$14,393
CGC INC - FULLERTON	3051	15/50	71,265	$1.37	$97,633	25,967	$18,271	$14,981
CGC INC - FULLERTON	3051	15/58	-	$1.36	$0	-	$0	$0
CGC INC - FULLERTON	3051	15/60	7,570	$2.29	$17,335	2,170	$2,552	$2,093
CGC INC - FULLERTON	3051	15/70	2,310	$2.55	$5,891	585	$766	$628
SOUTH COUNTY - LAGUNA	8002	15/10	270,483	$1.30	$351,628	24,950	$16,659	$13,658
SOUTH COUNTY - LAGUNA	8002	15/40	817,395	$1.25	$1,021,744	63,124	$40,526	$33,227
SOUTH COUNTY - LAGUNA	8002	15/50	83,336	$1.25	$104,170	9,809	$6,297	$5,163
SOUTH COUNTY - LAGUNA	8002	15/58	129	$1.06	$137	129	$70	$58
SOUTH COUNTY - LAGUNA	8002	15/60	104,287	$2.68	$279,489	12,486	$17,186	$14,091
SOUTH COUNTY - LAGUNA	8002	15/70	9,502	$1.87	$17,769	1,310	$1,258	$1,032
CGC INC - SANTA ANA	8034	15/10	92,457	$1.61	$148,856	15,575	$12,879	$10,559
CGC INC - SANTA ANA	8034	15/40	244,921	$1.61	$394,323	26,391	$21,823	$17,892
CGC INC - SANTA ANA	8034	15/50	4,250	$1.61	$6,843	1,532	$1,267	$1,039
CGC INC - SANTA ANA	8034	15/58	-	$1.36	$0	-	$0	$0
CGC INC - SANTA ANA	8034	15/60	12,171	$2.70	$32,862	2,129	$2,952	$2,421
CGC INC - SANTA ANA	8034	15/70	2,730	$3.00	$8,190	278	$428	$351
WESTERN YOUTH GARDEN GROVE	8035	15/10	86,149	$1.22	$105,102	23,391	$14,657	$12,017
WESTERN YOUTH GARDEN GROVE	8035	15/40	255,574	$1.22	$311,800	47,129	$29,531	$24,212
WESTERN YOUTH GARDEN GROVE	8035	15/50	13,648	$1.22	$16,651	4,467	$2,799	$2,295
WESTERN YOUTH GARDEN GROVE	8035	15/58	-	$1.22	$0	-	$0	$0
WESTERN YOUTH GARDEN GROVE	8035	15/60	17,882	$1.22	$21,816	4,625	$2,898	$2,376
WESTERN YOUTH GARDEN GROVE	8035	15/70	3,862	$1.22	$4,712	1,207	$756	$620
O.C.- ORANGE-CITY DR.	8042	15/10	-	$1.30	$0	-	$0	$0
O.C.- ORANGE-CITY DR.	8042	15/40	4,455	$1.25	$5,569	4,455	$2,860	$2,345
O.C.- ORANGE-CITY DR.	8042	15/50	-	$1.25	$0	-	$0	$0
O.C.- ORANGE-CITY DR.	8042	15/60	2,573	$2.68	$6,896	2,573	$3,542	$2,904
O.C.- ORANGE-CITY DR.	8042	15/70	200	$1.87	$374	200	$192	$157
WYS - LAGUNA	8056	15/10	148,531	$1.22	$181,208	16,632	$10,421	$8,545
WYS - LAGUNA	8056	15/40	558,191	$1.22	$680,993	45,485	$28,501	$23,368
WYS - LAGUNA	8056	15/50	31,073	$1.22	$37,909	3,965	$2,484	$2,037
WYS - LAGUNA	8056	15/60	50,168	$1.22	$61,205	5,351	$3,353	$2,749
WYS - LAGUNA	8056	15/70	2,510	$1.22	$3,062	-	$0	$0
WYS - ANAHEIM	8090	15/10	31,340	$1.22	$38,235	13,910	$8,716	$7,146
WYS - ANAHEIM	8090	15/40	132,302	$1.22	$161,408	65,208	$40,859	$33,500
WYS - ANAHEIM	8090	15/50	1,810	$1.22	$2,208	1,810	$1,134	$930
WYS - ANAHEIM	8090	15/60	15,965	$1.22	$19,477	9,352	$5,860	$4,805
WYS - ANAHEIM	8090	15/70	217	$1.22	$265	-	$0	$0

Prepared by HCA Accounting/Howard Thomas 1/14/10

Attachment B-1

COUNTY OF ORANGE
SUMMARY OF AB 3632 TREATMENT COSTS
FY 2000 - 2001

TREATMENT

PROVIDER NAME	PROVIDER #	SFC CODE	UNITS	RATE	TOTAL	MC Units	51.36% FFP	42.11% EPSDT
Anaheim JHSD	8091	15/10	3,920	$2.12	$8,310	3,626	$3,948	$3,237
Anaheim JHSD	8091	15/40	24,616	$1.96	$48,247	22,524	$22,674	$18,590
Anaheim JHSD	8091	15/50	120	$2.12	$254	120	$131	$107
Anaheim JHSD	8091	15/60	-	$0.00	$0	-	$0	$0
Anaheim JHSD	8091	15/70	-	$0.00	$0	-	$0	$0
NORTH COUNTY - PLACENTIA	8067	15/10	144,155	$1.30	$187,402	25,680	$17,146	$14,058
NORTH COUNTY - PLACENTIA	8067	15/40	424,519	$1.25	$530,649	57,869	$37,152	$30,461
NORTH COUNTY - PLACENTIA	8067	15/50	1,920	$1.25	$2,400	240	$154	$126
NORTH COUNTY - PLACENTIA	8067	15/60	140,776	$2.68	$377,280	39,572	$54,469	$44,659
NORTH COUNTY - PLACENTIA	8067	15/70	6,152	$1.87	$11,504	2,753	$2,644	$2,168
OLIVE CREST - ANAHEIM	8078	15/10	237	$1.94	$460	237	$236	$194
OLIVE CREST - ANAHEIM	8078	15/40	2,620	$1.57	$4,113	2,620	$2,113	$1,732
OLIVE CREST - ANAHEIM	8078	15/50	-	$1.55	$0	-	$0	$0
OLIVE CREST - ANAHEIM	8078	15/60	3,845	$1.54	$5,921	3,845	$3,041	$2,493
OLIVE CREST - ANAHEIM	8078	15/70	1,359	$1.37	$1,862	1,359	$956	$784
ASPEN HEALTH SERVICES - CM	30BC	15/10	4,070	$1.66	$6,756	839	$715	$586
ASPEN HEALTH SERVICES - CM	30BC	15/40	55,246	$1.66	$91,708	21,045	$17,942	$14,711
ASPEN HEALTH SERVICES - CM	30BC	15/50	-	$1.66	$0	-	$0	$0
ASPEN HEALTH SERVICES - CM	30BC	15/60	2,315	$3.08	$7,130	1,375	$2,175	$1,783
ASPEN HEALTH SERVICES - CM	30BC	15/70	383	$2.48	$950	321	$409	$335
ASPEN HEALTH SERVICES - GG	30BE	15/10	3,507	$1.66	$5,822	83	$71	$58
ASPEN HEALTH SERVICES - GG	30BE	15/40	11,484	$1.66	$19,063	1,795	$1,530	$1,255
ASPEN HEALTH SERVICES - GG	30BE	15/50	-	$1.66	$0	-	$0	$0
ASPEN HEALTH SERVICES - GG	30BE	15/60	1,155	$3.08	$3,557	82	$130	$106
ASPEN HEALTH SERVICES - GG	30BE	15/70	217	$2.48	$538	217	$276	$227
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/10	938	$1.66	$1,557	86	$73	$60
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/40	4,891	$1.66	$8,119	1,576	$1,344	$1,102
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/50	-	$1.66	$0	-	$0	$0
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/60	214	$3.08	$659	53	$84	$69
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/70	-	$2.48	$0	-	$0	$0
LATINO PSYCH CENTER	30AE	15/10	5,851	$2.06	$12,053	730	$772	$633
LATINO PSYCH CENTER	30AE	15/40	27,928	$2.06	$57,532	4,825	$5,105	$4,186
LATINO PSYCH CENTER	30AE	15/50	305	$2.06	$628	-	$0	$0
LATINO PSYCH CENTER	30AE	15/60	1,820	$3.84	$6,989	300	$592	$485
LATINO PSYCH CENTER	30AE	15/70	30	$3.09	$93	-	$0	$0
WYS - LAGUNA HILLS	30CH	15/10	5,215	$1.22	$6,362	592	$371	$304
WYS - LAGUNA HILLS	30CH	15/40	20,762	$1.22	$25,330	1,650	$1,034	$848
WYS - LAGUNA HILLS	30CH	15/50	538	$1.22	$656	122	$76	$63
WYS - LAGUNA HILLS	30CH	15/60	1,480	$1.22	$1,806	150	$94	$77
WYS - LAGUNA HILLS	30CH	15/70	-	$1.22	$0	-	$0	$0
WYS - HUNTINGTON BECAH	30AG	15/10	3,066	$1.22	$3,741	940	$589	$483
WYS - HUNTINGTON BECAH	30AG	15/40	14,293	$1.22	$17,437	1,284	$805	$660
WYS - HUNTINGTON BECAH	30AG	15/50	1,845	$1.22	$2,251	1,845	$1,156	$948
WYS - HUNTINGTON BECAH	30AG	15/60	1,459	$1.22	$1,780	159	$100	$82
WYS - HUNTINGTON BECAH	30AG	15/70	477	$1.22	$582	75	$47	$39
CGC - BUENA PARK	30CE	15/10	5,173	$1.23	$6,363	762	$481	$395
CGC - BUENA PARK	30CE	15/40	11,618	$1.23	$14,290	1,565	$989	$811
CGC - BUENA PARK	30CE	15/50	740	$1.23	$910	-	$0	$0
CGC - BUENA PARK	30CE	15/58	-	$1.36	$0	-	$0	$0
CGC - BUENA PARK	30CE	15/60	565	$2.07	$1,170	60	$64	$52
CGC - BUENA PARK	30CE	15/70	65	$2.29	$149	-	$0	$0
PACIFIC CLINICS	30AZ	15/10	-	$1.56	$0	-	$0	$0
PACIFIC CLINICS	30AZ	15/40	390	$1.56	$608	-	$0	$0

Prepared by HCA Accounting/Howard Thomas 1/14/10

COUNTY OF ORANGE
SUMMARY OF AB 3632 TREATMENT COSTS
FY 2000 - 2001

TREATMENT

PROVIDER NAME	PROVIDER #	SFC CODE	UNITS	RATE	TOTAL	MC Units	51.36% FFP	42.11% EPSDT
PACIFIC CLINICS	30AZ	15/50	-	$1.56	$0	-	$0	$0
PACIFIC CLINICS	30AZ	15/58	-	$1.56	$0	-	$0	$0
PACIFIC CLINICS	30AZ	15/60	141	$2.90	$409	-	$0	$0
PACIFIC CLINICS	30AZ	15/70	-	$2.33	$0	-	$0	$0
SCCS	30CD	15/10	1,061	$2.12	$2,249	205	$223	$183
SCCS	30CD	15/40	12,444	$2.12	$26,381	2,610	$2,842	$2,330
SCCS	30CD	15/50	13,663	$2.12	$28,966	1,492	$1,625	$1,332
SCCS	30CD	15/58	0	$2.12	$0	-	$0	$0
SCCS	30CD	15/60	0	$3.95	$0	-	$0	$0
SCCS	30CD	15/70	0	$3.18	$0	-	$0	$0
MENTAL HEALTH SYSTEMS	30CA	15/10	615	$2.12	$1,304	310	$338	$277
MENTAL HEALTH SYSTEMS	30CA	15/40	1,509	$2.12	$3,199	45	$49	$40
MENTAL HEALTH SYSTEMS	30CA	15/50	-	$2.12	$0	-	$0	$0
MENTAL HEALTH SYSTEMS	30CA	15/58	-	$2.12	$0	-	$0	$0
MENTAL HEALTH SYSTEMS	30CA	15/60	2,060	$3.95	$8,137	380	$771	$632
MENTAL HEALTH SYSTEMS	30CA	15/70	135	$3.18	$429	135	$220	$181
OLIVE CREST - SANTA ANA	30AU	15/10	-	$1.94	$0	-	$0	$0
OLIVE CREST - SANTA ANA	30AU	15/40	-	$1.57	$0	-	$0	$0
OLIVE CREST - SANTA ANA	30AU	15/50	29	$1.55	$45	-	$0	$0
OLIVE CREST - SANTA ANA	30AU	15/58	-	$0.57	$0	-	$0	$0
OLIVE CREST - SANTA ANA	30AU	15/60	10	$1.54	$15	-	$0	$0
OLIVE CREST - SANTA ANA	30AU	15/70	-	$1.37	$0	-	$0	$0
LATINO PSYCH CENTER	30BB	15/10	1,448	$2.06	$2,983	-	$0	$0
LATINO PSYCH CENTER	30BB	15/40	4,147	$2.06	$8,543	-	$0	$0
LATINO PSYCH CENTER	30BB	15/50	-	$2.06	$0	-	$0	$0
LATINO PSYCH CENTER	30BB	15/60	525	$3.84	$2,016	-	$0	$0
LATINO PSYCH CENTER	30BB	15/70	-	$3.09	$0	-	$0	$0
SUB TOTAL			**5,922,635**		**$8,343,200**	**992,628**	**$748,168**	**$613,422**
Medication Monitoring		15/60			($1,329,201)		($155,150)	($127,207)
Crisis Intervention		15/70			($80,590)		($12,670)	($10,388)
TBS		15/58			($137)		($70)	($58)
Total					$6,933,272		$580,278	$475,769
Audit Report					$6,933,272 FR: B-4		$580,278	$885,473
Difference					$0	-	($0)	($409,704) (1)

Total Net Expenditures Incorrectly Reduced **($1,046,844)** (2)

(1) Difference pertains to State categorical funding in the amount of $409,704 that was applied to Treatment for FY 00/01.
(2) The total Medication Monitoring Costs are offset by corresponding revenues ($1,329,201 less FFP of $155,150 and EPSDT of $127,207).

Prepared by HCA Accounting/Howard Thomas 1/14/10 6

Schedule 1—
Summary of Program Costs
July 1, 2000, through June 30, 2002

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustment	Reference [1]
July 1, 2000, through June 30, 2001				
Assessment/case management costs	$ 5,426,476	$ 4,895,673	$ (530,803)	Finding 3
Administrative costs	2,516,904	1,648,944	(867,960)	Finding 1
Offsetting revenues:				
State categorical funds	(329,822)	(409,436)	(79,614)	Finding 2
Short-Doyle/Medi-Cal funds	—	(624,993)	(624,993)	Finding 2
Other	—	—	—	
Net assessment/case management costs	7,613,558	5,510,188	(2,103,370)	
Treatment costs	9,223,879	6,933,272	(2,290,607)	Finding 3
Administrative costs	3,409,319	2,053,402	(1,355,917)	Finding 1
Offsetting revenues:				
State general/realignment funds	(5,998,426)	(5,998,426)	—	
State categorical funds	(699,001)	(885,473)	(186,472)	Finding 2
Short-Doyle/Medi-Cal funds	(625,439)	(580,278)	45,161	Finding 2
Other	(92,549)	(92,549)	—	
Net treatment costs	5,217,783	1,429,948	(3,787,835)	
Subtotal	$ 12,831,341	6,940,136	$ (5,891,205)	
Less allowable costs that exceed claimed costs [2]		—		
Total program costs		6,940,136		
Less amount paid by the State		(9,511,041)		
Allowable costs claimed in excess of (less than) amount paid		$ (2,570,905)		
July 1, 2001, through June 30, 2002				
Assessment/case management costs	$ 5,407,140	$ 7,021,087	$ 1,613,947	Finding 3
Administrative costs	3,209,823	2,549,043	(660,780)	Finding 1
Offsetting revenues:				
State categorical funds	(933,938)	(533,817)	400,121	Finding 2
Short-Doyle/Medi-Cal funds	—	(745,974)	(745,974)	Finding 2
Other	—	—	—	
Net assessment/case management costs	7,683,025	8,290,339	607,314	
Treatment costs	9,544,249	11,710,936	2,166,687	Finding 3
Administrative costs	4,526,546	3,715,094	(811,452)	Finding 1
Offsetting revenues:				
State general/realignment funds	—	—	—	
State categorical funds	(699,001)	(1,193,541)	(494,540)	Finding 2
Short-Doyle/Medi-Cal funds	(1,660,639)	(928,157)	732,482	Finding 2
Other	(92,549)	(92,549)	—	

Hearing Date: August 29, 1996
File Number: CSM-4282
Commission Staff: Lucila Ledesma
LL\4282\RevP&G.Amd

Original Adopted: 8/22/9 1
Revised: 8/29/96

PARAMETERSANDGUIDELINES

Sections 60000-60200
Title 2, California Code of Regulations, Division 9
Chapter 1747, Statutes of 1984
Chapter 1274, Statutes of 1985
Handicapped and Disabled Students

I. SUMMARY OF MANDATE

Chapter 1747 of the Statutes of 1984 added Chapter 26, commencing with section 7570, to Division 7 of Title 1 of the Government code (Gov. Code).

Chapter 1274 of the Statutes of 1985 amended sections 7572, 7572.5, 7575, 7576, 7579, 7582, and 7587 of, amended and repealed 7583 of, added section 7586.5 and 7586.7 to, and repealed 7574 of, the Gov. Code, and amended section 5651 of the Welfare and Institutions Code.

To the extent that Gov. Code section 7572 and section 60040, Title 2, Code of California Regulations, require county participation in the mental health assessment for "'individuals with exceptional needs, " such legislation and regulations impose a new program or higher level of service upon a county. Furthermore, any related county participation on the expanded "Individualized Education Program" (IEP) team and case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed, " pursuant to subdivisions (a), (b), and (c) of Gov. Code section 7572.5 and their implementing regulations, impose a new program or higher level of service upon a county.

The aforementioned mandatory county participation in the IEP process is not subject to the Short-Doyle Act, and accordingly, such costs related thereto are costs mandated by the state and are fully reimbursable within the meaning of section 6, article XIIIB of the California Constitution.

The provisions of Welfare and Institutions Code section 565 1, subdivision (g), result in a higher level of service within the county Short-Doyle program because the mental health services, pursuant to Gov. Code sections 757 1 and 7576 and their implementing regulations, must be included in the county Short-Doyle annual plan. Such services include psychotherapy and other mental health services provided to "individuals with exceptional needs, " including those designated as "seriously emotionally disturbed, " and required in such individual's IEP.

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Attachment C

California Government Code Section 7576

(a) The State Department of Mental Health, or a community mental health service, as described in Section 5602 of the Welfare and Institutions Code, designated by the State Department of Mental Health, is responsible for the provision of mental health services, **as defined in regulations by the State Department of Mental Health,** developed in consultation with the State Department of Education, if required in the individualized education program of a pupil. A local educational agency is not required to place a pupil in a more restrictive educational environment in order for the pupil to receive the mental health services specified in his or her individualized education program if the mental health services can be appropriately provided in a less restrictive setting. It is the intent of the Legislature that the local educational agency and the community mental health service vigorously attempt to develop a mutually satisfactory placement that is acceptable to the parent and addresses the educational and mental health treatment needs of the pupil in a manner that is cost effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment. For purposes of this section, "parent" is as defined in Section 56028 of the Education Code.

(b) A local educational agency, individualized education program team, or parent may initiate a referral for assessment of the social and emotional status of a pupil, pursuant to Section 56320 of the Education Code. Based on the results of assessments completed pursuant to Section 56320 of the Education Code, an individualized education program team may refer a pupil who has been determined to be an individual with exceptional needs, as defined in Section 56026 of the Education Code, and who is suspected of needing mental health services to a community mental health service if the pupil meets all of the criteria in paragraphs (1) to (5), inclusive. Referral packages shall include all documentation required in subdivision (c), and shall be provided immediately to the community mental health service.

(1) The pupil has been assessed by school personnel in accordance with Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code. Local educational agencies and community mental health services shall work collaboratively to ensure that assessments performed prior to referral are as useful as possible to the community mental health service in determining the need for mental health services and the level of services needed.

(2) The local educational agency has obtained written parental consent for the referral of the pupil to the community mental health service, for the release and exchange of all relevant information between the local educational agency and the community mental health service, and for the observation of the pupil by mental health professionals in an educational setting.

(3) The pupil has emotional or behavioral characteristics that satisfy all of the following:

(A) Are observed by qualified educational staff in educational and other settings, as appropriate.

(B) Impede the pupil from benefiting from educational services.

(C) Are significant as indicated by their rate of occurrence and intensity.

Attachment D-1

(D) Are associated with a condition that cannot be described solely as a social maladjustment or a temporary adjustment problem, and cannot be resolved with short-term counseling.

(4) As determined using educational assessments, the pupil's functioning, including cognitive functioning, is at a level sufficient to enable the pupil to benefit from mental health services.

(5) The local educational agency, pursuant to Section 56331 of the Education Code, has provided appropriate counseling and guidance services, psychological services, parent counseling and training, or social work services to the pupil pursuant to Section 56363 of the Education Code, or behavioral intervention as specified in Section 56520 of the Education Code, as specified in the individualized education program and the individualized education program team has determined that the services do not meet the educational needs of the pupil, or, in cases where these services are clearly inadequate or inappropriate to meet the educational needs of the pupil, the individualized education program team has documented which of these services were considered and why they were determined to be inadequate or inappropriate.

(c) If referring a pupil to a community mental health service in accordance with subdivision (b), the local educational agency or the individualized education program team shall provide the following documentation:

(1) Copies of the current individualized education program, all current assessment reports completed by school personnel in all areas of suspected disabilities pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code, and other relevant information, including reports completed by other agencies.

(2) A copy of the parent's consent obtained as provided in paragraph (2) of subdivision (b).

(3) A summary of the emotional or behavioral characteristics of the pupil, including documentation that the pupil meets the criteria set forth in paragraphs (3) and (4) of subdivision (b).

(4) A description of the counseling, psychological, and guidance services, and other interventions that have been provided to the pupil, as provided in the individualized education program of the pupil, including the initiation, duration, and frequency of these services, or an explanation of the reasons a service was considered for the pupil and determined to be inadequate or inappropriate to meet his or her educational needs.

(d) Based on preliminary results of assessments performed pursuant to Section 56320 of the Education Code, a local educational agency may refer a pupil who has been determined to be, or is suspected of being, an individual with exceptional needs, and is suspected of needing mental health services, to a community mental health service if a pupil meets the criteria in paragraphs (1) and (2). Referral packages shall include all documentation required in subdivision (e) and shall be provided immediately to the community mental health service.

(1) The pupil meets the criteria in paragraphs (2) to (4), inclusive, of subdivision (b).

(2) Counseling and guidance services, psychological services, parent counseling and training, social work services, and behavioral or other interventions as provided in the individualized education program of the pupil are clearly inadequate or inappropriate in

meeting his or her educational needs.

(e) If referring a pupil to a community mental health service in accordance with subdivision (d), the local educational agency shall provide the following documentation:

(1) Results of preliminary assessments to the extent they are available and other relevant information including reports completed by other agencies.

(2) A copy of the parent's consent obtained as provided in paragraph (2) of subdivision (b).

(3) A summary of the emotional or behavioral characteristics of the pupil, including documentation that the pupil meets the criteria in paragraphs (3) and (4) of subdivision (b).

(4) Documentation that appropriate related educational and designated instruction and services have been provided in accordance with Sections 300.34 and 300.39 of Title 34 of the Code of Federal Regulations.

(5) An explanation of the reasons that counseling and guidance services, psychological services, parent counseling and training, social work services, and behavioral or other interventions as provided in the individualized education program of the pupil are clearly inadequate or inappropriate in meeting his or her educational needs.

(f) The procedures set forth in this chapter are not designed for use in responding to psychiatric emergencies or other situations requiring immediate response. In these situations, a parent may seek services from other public programs or private providers, as appropriate. This subdivision does not change the identification and referral responsibilities imposed on local educational agencies under Article 1 (commencing with Section 56300) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code.

(g) Referrals shall be made to the community mental health service in the county in which the pupil lives. If the pupil has been placed into residential care from another county, the community mental health service receiving the referral shall forward the referral immediately to the community mental health service of the county of origin, which shall have fiscal and programmatic responsibility for providing or arranging for the provision of necessary services. The procedures described in this subdivision shall not delay or impede the referral and assessment process.

(h) A county mental health agency does not have fiscal or legal responsibility for costs it incurs prior to the approval of an individualized education program, except for costs associated with conducting a mental health assessment.

This database is current through 1/8/10 Register 2010, No. 2

§ 60020. Mental Health Definitions.

(a) "Community mental health service" means a mental health program established by a county in accordance with the Bronzan-McCorquodale Act, Part 2 (commencing with Section 5600) of Division 5 of the Welfare and Institutions Code.

(b) "County of origin" for mental health services is the county in which the parent of a pupil with a disability resides. If the pupil is a ward or dependent of the court, an adoptee receiving adoption assistance, or a conservatee, the county of origin is the county where this status currently exists. For the purposes of this program the county of origin shall not change for pupils who are between the ages of 18 and 22.

(c) "Expanded IEP team" means an IEP team constituted in accordance with Section 7572.5 of the Government Code. This team shall include a representative of the community mental health service authorized to make placement decisions.

(d) "Host county" means the county where the pupil with a disability is living when the pupil is not living in the county of origin.

(e) "Local mental health director" means the officer appointed by the governing body of a county to manage a community mental health service.

(f) "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness.

(g) "Mental health assessment" is a service designed to provide formal, documented evaluation or analysis of the nature of the pupil's emotional or behavioral disorder. It is conducted in accordance with California Code of Regulations, Title 9, Section 543(b), and Sections 56320 through 56329 of the Education Code by qualified mental health professionals employed by or under contract with the community mental health service.

(h) "Mental health assessment plan" means a written statement developed for the individual evaluation of a pupil with a disability who has been referred to a community mental health service to determine the need for mental health services in accordance with Section 56321 of the Education Code.

(i) "Mental health services" means mental health assessments and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code: psychotherapy as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management. These services shall be provided directly or by contract at the discretion of the community mental health service of the county of origin.

(j) "Qualified mental health professional" includes the following licensed practitioners of the healing arts: a psychiatrist; psychologist; clinical social worker; marriage, family and child counselor; registered nurse, mental health rehabilitation specialist, and others who have been waivered under Section 5751.2 of the Welfare and Institutions Code. Such individuals may provide mental health

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services, consistent with their scope of practice.

Note: Authority cited: Section 7587, Government Code. Reference: Section 56320, Education Code; and Sections 542 and 543, Title 9, California Code of Regulations.

HISTORY

1. New section refiled 5-1-87 as an emergency; designated effective 5-1-87 (Register 87, No. 30). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 8-31-87.

2. Division 9 (Chapter 1, Articles 1-9, Sections 60000-60610, not consecutive) shall not be subject to automatic repeal until the final regulations take effect on or before June 30, 1988 pursuant to Item 4440-131-001(b)(2), Chapter 135, Statutes of 1987 (Register 87, No. 46).

3. Division 9 (Chapter 1, Articles 1-9, Sections 60000-60610, not consecutive) shall not be subject to automatic repeal until the final regulations take effect on or before June 30, 1997, pursuant to Government Code section 7587, as amended by Stats. 1996, c. 654 (A.B. 2726, s4.) (Register 98, No. 26).

4. Division 9 (Chapter 1, Articles 1-9, Sections 60000-60610, not consecutive) repealed June 30, 1997, by operation of Government Code section 7587, as amended by Stats. 1996, c. 654 (A.B. 2726, s4.) (Register 98, No. 26).

5. New section filed 6-26-98 as an emergency; operative 7-1-98 (Register 98, No. 26). A Certificate of Compliance must be transmitted to OAL by 10-29-98 or emergency language will be repealed by operation of law on the following day.

6. Editorial correction restoring prior Histories 1-2, adding new Histories 3-4, and renumbering and amending existing History 1 to new History 5 (Register 98, No. 44).

7. New section refiled 10-26-98 as an emergency; operative 10-29-98 (Register 98, No. 44). A Certificate of Compliance must be transmitted to OAL by 2-26-99 or emergency language will be repealed by operation of law on the following day.

8. New section refiled 2-25-99 as an emergency; operative 2-26-99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-28-99 or emergency language will be repealed by operation of law on the following day.

9. Certificate of Compliance as to 2-25-99 order, including amendment of subsections (b), (c) and (j), transmitted to OAL 6-25-99 and filed 8-9-99 (Register 99, No. 33).

Exhibit A

SERVICES TO HANDICAPPED STUDENTS

1. Summary of Chapters 1747/84 and 1274/85

Chapter 1747, Statutes of 1984, added Chapter 26, commencing with § 7570, to Division 7 of Title 1 of the Government Code.

Chapter 1274, Statutes of 1985, amended Government Code § § 7572, 7572.5, 7575, 7576, 7579, 7582, and 7587; amended and repealed § 7583; added § 7586.5 and 7586.7; repealed § 7574 and amended § 5651 of the Welfare and Institutions Code. To the extent that Government Code § 7572 and § 60040, Title 2, Code of California Regulations, require county participation in the mental health assessment for "individuals with exceptional needs," such legislation and regulations impose a new program or higher level of service upon a county. Furthermore, any related county participation in the expanded "Individualized Education Program" (IEP) team and case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed", pursuant to Subdivisions (a), (b), and (c) of Government Code § 7572.5 and their implementing regulations.

The aforementioned mandatory county participation in the IEP process is not subject to the Short Doyle Act, and accordingly, such costs related thereto, are costs mandated by the state and are fully reimbursable within the meaning of § 6, Article XIIIB of the California Constitution.

The provisions of Welfare and Institutions Code § 5651, Subdivision (g), result in a higher level of service within the county Short-Doyle program because pursuant to Government Code § § 7571 and 7576 and their implementing regulations, the mental health services must be included in the county Short-Doyle annual plan. Such services include psychotherapy and other mental health services provided to "individuals with exceptional needs", including those designated as "seriously emotionally disturbed", and required in such individual's IEP.

Such mental health services are subject to the current cost sharing formula of the Short-Doyle Act, through which the state provides ninety (90) percent of the total costs of the Short-Doyle program, and the county is required to provide the remaining ten (10) percent of the funds. Accordingly, only ten (10) percent of such program costs are reimbursable within the meaning of § 6, Article XIIIB of the California Constitution as costs mandated by the state, because the Short-Doyle Act currently provides counties ninety (90) percent of the costs of furnishing those mental health services set forth in Government Code § § 7571 and 7576 and their implementing regulations, and described in the county's Short-Doyle annual plan pursuant to Welfare and Institutions Code § 5651, Subdivision (g).

On April 26, 1990, the Commission on State Mandates determined that Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 resulted in state mandated costs that are reimbursable pursuant to Part 7 (commencing with Government Code § 17500) of Division 4 of Title 2. The Commission determined that county participation in the IEP process is a state mandated program and any related cost is fully reimbursable. Furthermore, any mental health treatment required by an IEP is subject to the Short-Doyle cost sharing formula. Consequently, only the county's Short-Doyle share (i.e., ten percent) of the mental health treatment costs will be reimbursed as costs mandated by the state.

2. Eligible Claimants

Any county incurring increased costs as a result of this mandate is eligible to claim reimbursement of these costs.

3. Appropriations

These claiming instructions are issued following the adoption of the program's amended parameters and guidelines by the Commission on State Mandates. Funds for payment of the 1994/95, 1995/96, 1996/97 costs are made available in state budget acts of these fiscal years.

To determine if this program is funded in subsequent fiscal years, refer to the schedule "Appropriations for State Mandated Cost Programs" in the "Annual Claiming Instructions for State Mandated Costs" issued in September of each year to county auditors.

4. Types of Claims

A. Reimbursement and Estimated Claims

A claimant may file a reimbursement and/or an estimated claim. A reimbursement claim details the costs actually incurred for a prior fiscal year. An estimated claim shows the costs to be incurred for the current fiscal year.

B. Minimum Claim

Government Code § 17564(a) provides that no claim shall be filed pursuant to Government Code § 17561 unless such a claim exceeds $200 per program per fiscal year.

5. Filing Deadline

A. Initial Claims

Initial claims must be filed within 120 days from the issuance date of claiming instructions. Accordingly:

(1) Reimbursement claims detailing the actual costs incurred for the 1994/95 and 1995/96 fiscal years must be filed with the State Controller's Office and post- marked by July 28, 1997. If the reimbursement claim is filed after the deadline of July 28, 1997, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

(2) Estimated claims for costs to be incurred during the 1996/97 fiscal year must be filed with the State Controller's Office and postmarked by July 28, 1997. Timely filed estimated claims are paid before late claims. If a payment is received for the estimated claim, a 1996/97 reimbursement claim must be filed by November 30, 1997.

B. Annually Thereafter

Refer to the item "Reimbursable State Mandated Cost Programs" contained in the annual cover letter for mandated cost programs issued annually in September, which identifies the fiscal years for which claims may be filed. If an "x" is shown for the program listed under "19__/19__ Reimbursement Claim," and/or "19__/19__ Estimated Claim," claims may be filed as follows:

(1) An estimated claim must be filed with the State Controller's Office and postmarked by November 30 of the fiscal year in which costs are to be incurred. Timely filed estimated claims will be paid before late claims.

After having received payment for an estimated claim, the claimant must file a reimbursement claim by November 30 of the following fiscal year. If the local agency fails to file a reimbursement claim, monies received for the estimated claim must be returned to the State. If no estimated claim was filed, the agency may file a reimbursement claim detailing the actual costs incurred for the fiscal year, provided there was an appropriation for the program for that fiscal year. For information regarding appropriations for reimbursement claims, refer to the "Appropriation for State Mandated Cost Programs" in the previous fiscal year's annual claiming instructions.

(2) A reimbursement claim detailing the actual costs must be filed with the State Controller's Office and postmarked by November 30 following the fiscal year in which costs were incurred. If the claim is filed after the deadline but by November 30 of the succeeding fiscal year, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

6. Reimbursable Components

Eligible claimants will be reimbursed for the direct and indirect cost of labor, supplies, and services incurred for the following mandated components:

A. Assessment, IEP Participation, Case Management

(1) The scope of the mandate is one hundred percent (100) percent reimbursement of any costs related to IEP Participation, Assessment, and Case Management, except for individuals billed to Medi-Cal only. The Federal Financing Participation portion (FFP) for these activities should be deducted from reimbursable activities not subject to the Short-Doyle Act.

(2) For each eligible claimant, the following cost items are one hundred (100%) percent reimbursable (G. C. § 7572, subd. (d)(1)):

(a) Whenever an LEA refers an individual suspected of being an "individual with exceptional needs" to the local mental health department, mental health assessment and recommendation by qualified mental health professionals in conformance with assessment procedures set forth in Article 2 (commencing with § 56320) of Chapter 4 of part 30 of Division 4 of the Education Code, and regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, including but not limited to the following mandated services:

i. Interview with the child and family

ii. Collateral interviews as necessary

iii. Review of the records

iv. Observation of the child at school

v. Psychological testing and/or psychiatric assessment, as necessary.

(b) Review and discussion of mental health assessment and recommendations with parent and appropriate IEP team members. (G. C. § 7572, subd. (d)(1)).

(c) Attendance by the mental health professional who conducted the assessment at IEP meetings, when requested. (G. C. § 7572, subd. (d)(1)).

(d) Review by claimant's mental health professional of any independent assessment(s) submitted by the IEP team. (G. C. 7572, subd. (d)(2)).

(e) When the written mental health assessment report provided by the local mental health program determines that an "individual with special needs" is seriously

emotionally disturbed", and any member of the IEP team recommends residential placement based upon relevant assessment information, inclusion of the claimant's mental health professional on that individual's expanded IEP team.

(f) When the IEP prescribes residential placement for an "individual with exceptional needs" who is "seriously emotionally disturbed," claimant's mental health personnel's identification of out-of-home placement, case management, six month review of IEP, and expanded IEP responsibilities. (G. C. § 7572.5).

(g) Required participation in due process procedures, including but not limited to due process hearings.

(b) One hundred (100%) percent of any administrative costs related to IEP Participation, Assessment, and Case Management, whether direct or indirect.

B. Treatment Services

Any costs related to mental health treatment services rendered under the Short-Doyle Act:

(1) The scope of the mandate is ten (10%) percent reimbursement.

(2) For each eligible claimant, the following cost items for the provision of mental health services when required by a child's individualized education program are ten (10%) percent reimbursable (G. C. § 7576):

(a) Individual therapy

(b) Collateral therapy and contacts

(c) Group therapy

(d) Day treatment

(e) Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.

(b) Ten (10%) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

7. **Reimbursement Limitations**

A. Any offsetting savings the claimant experiences as a direct result of this statute must be deducted from the costs claimed.

B. The following reimbursements for this mandate shall be deducted from the claim:

1. Any direct payments (categorical funding) received form the State which are specifically allocated to this program.

2. Any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g., federal, state, etc.

8. **Claiming Forms and Instructions**

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms HDS-1, HDS-2, HDS-3, HDS-4, HDS-5, and HDS-6 provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions should be duplicated and used by the claimant to file estimated or reimbursement claims. The State Controller's Office will revise the manual and claim forms as necessary. In such instances, new replacement forms will be mailed to claimants.

9. Claim Preparation

There are two satisfactory methods of submitting claims for reimbursement of increased costs incurred to comply with the mandate:

A. Cost Report Method

Under this claiming method a complete copy of the annual cost report including all supporting schedules attached to the cost report as filed with DMH must also be filed with the claim forms submitted to the State Controller.

To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions:

Ten (10%) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs that exceed ten (10%) percent of total program direct labor costs, excluding fringe benefits.

OR if an indirect cost rate greater than ten (10%) is being claimed:

By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations that further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program, each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP's.

1. **Form HDS-6, Component/Activity Cost Detail**

   This form is used to detail the cost of administration for Assessment, IEP Participation, Case Management and Mental Health Treatment. The indirect costs summarized on this form must be carried forward to HDS-3, line (03)(e) or HDS-3, line (03)(g), as appropriate.

   Indirect costs may be computed as ten (10%) of direct labor costs, excluding fringe benefits. If an indirect cost rate greater than ten (10%) is used, include the Indirect Cost Proposal (ICRP) with the claim. If more than one department is involved in the mandated costs program, each department must have their own ICRP.

2. **Form HDS-5, Component/Activity Cost Detail**

   This form is used to detail the cost of due process proceedings. Claim statistics shall identify the amount of work performed during the period in which costs are claimed. The claimant must provide the number of due process proceedings. The cost summarized on this form must be carried forward to HDS-3, line (03)(d).

   Indirect costs may be computed as ten (10%) of direct labor costs, excluding fringe benefits. If an indirect cost rate greater than ten (10%) is used, include the Indirect Cost Proposal (ICRP) with the claim. If more than one department is involved in the mandated costs program, each department must have their own ICRP.

3. **Form HDS-4, Component/Activity Cost Detail**

   This form is used to segregate the detailed cost by claim component. Information required to complete this form: (a) Name of Providers, (b) Provider I.D. Numbers, (c) Service Function Codes, (d) Units of Service, and (e) Rate Per

Unit. Carry forward the total from line (05) column (f) to form HDS-3, block (03) in the appropriate line.

4. **Form HDS-3, Claim Summary**

This form is used to summarize the cost from forms HDS-4, HDS-5, and HDS-6. The cost must be reduced by the amount of funds received from Non-Categorical State General/Realignment Funds, State Categorical Funds, Short-Doyle/Medi Cal (FFP only), and other funds that reimburse any portion of the mandate. The total claimed amount on this form is carried forward to form FAM-27.

B. **Actual Increased Cost Method**

Report actual increased costs incurred for each of the following expense categories in the format specified by the State Controller's claiming instructions. Attach supporting schedules as necessary.

1. **Form HDS-2, Component/Activity Cost Detail**

This form is used to segregate the detailed cost by claim component. A separate form HDS-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(a) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed by each employee and specify the actual time spent, the productive hourly rate and related fringe benefits.

Source documents required to be maintained by the claimant may include, but are not limited to, employee time records that show the employee's actual time spent on this mandate.

(b) Materials and Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of materials consumed or expended specifically for the purpose of this mandate.

Source documents required to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase orders and other documents evidencing the validity of the expenditures.

(c) Contracted Services

Contracting costs are reimbursable to the extent that the function to be performed requires special skill or knowledge that is not readily available from the claimant's staff or the service to be provided by the contractor is cost effective. Use of contract services must be justified by the claimant.

Give the name(s) of the contractor(s) who performed the services. Describe the activities performed by each named contractor, actual time spent on this mandate, inclusive dates when services were performed, and itemize all costs for services performed. Attach consultant invoices with the claim.

Source documents required to be maintained by the claimant may include, but are not limited to, contracts, invoices, and other documents evidencing the validity of the expenditures.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

2. **Form HDS-1, Claim Summary**

This form is used to summarize direct costs by cost component and compute allowable indirect costs for the mandate. Direct costs summarized on this form are derived from form HDS-2 and carried forward to form FAM-27.

One hundred (100%) of any indirect administrative costs related to IEP participation, assessment, case management, and ten percent (10%) of mental health treatment rendered under the Short-Doyle Act may be claimed to the extent that reimbursable indirect costs have not already been reimbursed by the DMH. Indirect costs may be claimed using either of two methods:

(a) Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs which exceed ten (10) percent of total program direct labor costs, excluding fringe benefits.

OR if an indirect cost rate greater than ten (10) percent is being claimed,

(b) By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program, each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP's.

C. **Form FAM-27, Claim for Payment**

This form contains a certification that must be signed by an authorized representative of the local agency. All applicable information from form HDS-1 or HDS-3 must be carried forward to this form for the State Controller's Office to process the claim for payment.

Illustration of Claim Forms

A. Cost Report Method

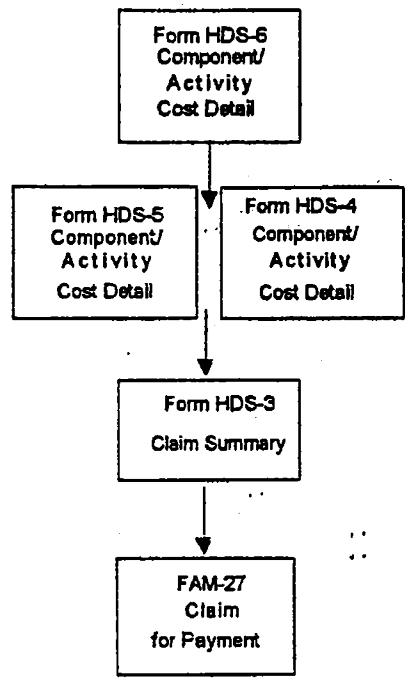
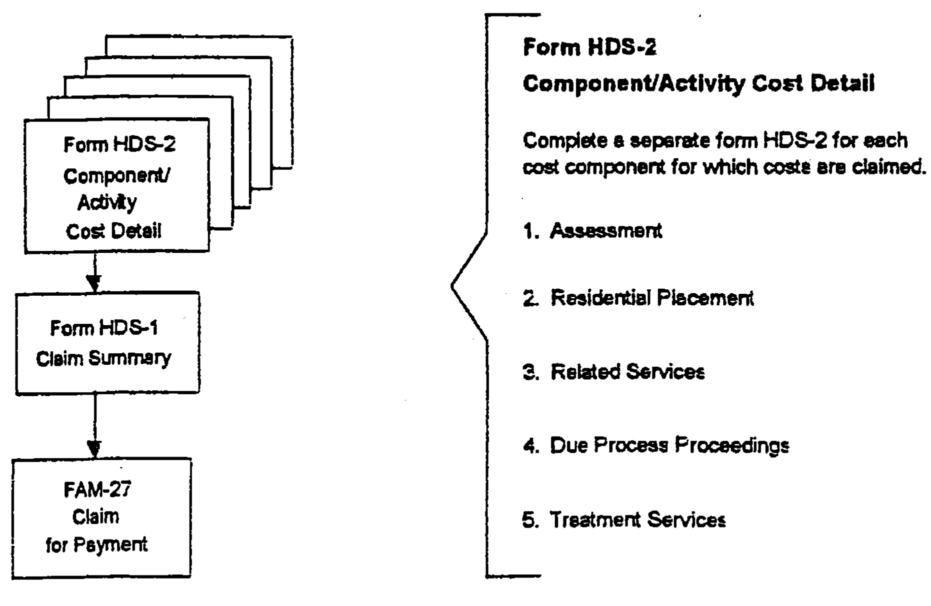


Illustration of Claim Forms

B. Actual Report Method



CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SERVICES TO HANDICAPPED STUDENTS

For State Controller Use Only
(19) Program Number 00111
(20) Date File ____/____/____
(21) LRS Input ____/____/____

		Reimbursement Claim Data	
(01) Claimant Identification Number		(22) HDS-1, (03)(a)	
(02) Mailing Address		(23) HDS-1, (03)(b)	
Claimant Name		(24) HDS-1, (03)(c)	
County of Location		(25) HDS-1, (04)(1)(d)	
Street Address or P. O.. Box		(26) HDS-1, (04)(2)(d)	
City State Zip Code			

Type of Claim	Estimated Claim	Reimbursement Claim	(27) HDS -1, (04)(3)(d)	
	(03) Estimated ☐	(09) Reimbursement ☐	(28) HDS-1, (04)(4)(d)	
	(04) Combined ☐	(10) Combined ☐	(29) HDS-1, (04)(5)(d)	
	(05) Amended ☐	(11) Amended ☐	(30) HDS-1, (06)	
Fiscal Year of Cost	(06) 19___/19___	(12) 19___/19___	(31) HDS-3, (05)	
Total Claimed Amount	(07)	(13)	(32) HDS-3, (06)	
Less: 10% Late Penalty, not to exceed $1,000		(14)	(33) HDS-3, (07)	
Less: Estimated Claim Payment Received		(15)	(34)	
Net Claimed Amount		(16)	(35)	
Due from State	(08)	(17)	(36)	
Due to State		(18)	(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 set forth on the attached statements.

Signature of Authorized Representative ______________________ Date ______________________

______________________ ______________________

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number ( ) Ext.

SERVICES TO HANDICAPPED STUDENTS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form HDS-1 and enter the amount from line (11) or complete form HDS-3 and enter the amount from line (15).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form HDS-1, line (11) or from form HDS-3, line (15), as appropriate.

(14) Filing Deadline. Amended Claims of Ch.1747/84 and Ch.1274/85. If the reimbursement claim for the 1994/95 or 1995/96 fiscal year is filed after July 28, 1997, the additional amount over the original claim must be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

Filing Deadline. Annually Thereafter. If the reimbursement claim is filed after November 30 following the fiscal year in which costs were incurred, the claim must be reduced by a late penalty.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (33) for the reimbursement claim [e.g., HDS-1 (03)(a), means the information is located on form HDS-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). The claim cannot be processed for payment unless this data block is correct and complete.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND ONE COPY OF FORM FAM-27, AND ONE COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by:
U.S. Postal Service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursement Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by:
Other delivery service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursement Section
Division of Accounting and Reporting
3301 C Street, Suite 501
Sacramento, CA 95816

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY	FORM HDS-1

(01) Claimant	(02) Type of Claim Reimbursement ☐ Estimated ☐	Fiscal Year 19___/19___

Claim Statistics	
(03)(a) Number of students who were suspected of being "individuals with exceptional needs," and were referred to the local mental health department for assessment and recommendation in the fiscal year of claim.	
(b) Number of students who required residential placements in the fiscal year of claim.	
(c) Number of due process proceedings that took place in the fiscal year of claim.	

Direct Costs				
(04) Reimbursable Components:	(a) Salaries	(b) Benefits	(c) Services and Supplies	(d) Total
1. Assessment				
2. Residential Placement				
3. Related Services				
4. Due Process Proceedings				
5. Treatment Services				
(05) Total Direct Costs				

Indirect Costs		
(06) Indirect Cost Rate	[From ICRP]	%
(07) Total Indirect Costs	[Line (06) x line (05)(a)] or [line (06) x [line (05)(a) + line (05)(b)]]	
(08) Total Direct and Indirect Costs	[Line (05)(d) + line (07)]	

Cost Reduction		
(09) Less: Offsetting Savings, if applicable		
(10) Less: Other Reimbursements, (i.e., State General/Realignment Funds, State Categorical Funds, Short-Doyle/Medi-Cal (FFP only), etc.)		
(11) Total Claimed Amount	[Line (08) - {Line (09) + line (10)}]	

SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY Instructions	FORM HDS-1

(01) Enter the name of the claimant. If more than one department has incurred costs for this mandate, give the name of each department. A form HDS-1 should be completed for each department

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form HDS-1 must be filed for a reimbursement claim. Do not complete form HDS-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form HDS-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) (a) Enter the number of students who were suspected of being "individuals with exceptional needs," and were referred to the local mental health department for assessment and recommendation in the fiscal year of claim.
(b) Enter the number of students who required residential placements in the fiscal year of claim.
(c) Enter the number of due process proceedings that took place in the fiscal year of claim.

(04) Reimbursable Components: For each reimbursable component , enter the totals from form HDS-2, line (05) columns (d), (e), and (f) to form HDS-1, block (04) columns (a), (b), and (c) in the appropriate row. Total each row.

(05) Total Direct Costs. Total columns (a) through (d).

(06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.

(07) Total Indirect Costs. Multiply Total Salaries, line (05)(a) by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply total Salaries and Benefits, line (05)(a) and line (05)(b) by the Indirect Cost Rate, line (06).

(08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(d) and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source, [i.e., State General/Realignment Funds, State Categorical Funds, Short-Doyle/Medi-Cal (FFP only), service fees collected, federal funds, other state funds, etc.,] which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09) and Other Reimbursements, line (10) from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL

FORM HDS-2

(01) Claimant	(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

- [ ] Assessment
- [ ] Due Process Proceedings
- [ ] Residential Placement
- [ ] Treatment Services
- [ ] Related Services

(04) Description of Expenses: Complete columns (a) through (f).

			Object Accounts		
(a) Employee Names, Job Classifications, Functions Performed and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Services and Supplies
(05) Total [ ] Subtotal [ ] Page:______of______					

SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL
Instructions

FORM HDS-2

(01) Enter the name of the claimant. If more than one department has incurred costs for this mandate, give the name of each department. A form HDS-2 should be completed for each department.

(02) Enter the fiscal year in which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form HDS-2 shall be prepared for each component which applies.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in line (03), enter the employee names, position titles, a brief description of their activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contracted services, etc. The **descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed. If the descriptions are incomplete, the claim cannot be processed for payment.** For audit purposes, all supporting documents must be retained by the claimant for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub-object Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name Title Activities Performed	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits		Benefit Rate		Salaries	Benefits = Benefit Rate x Salaries		
Services and Supplies Office Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Consumed	
Contracted Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Itemize Cost of Services Performed	Invoice

(05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed for the component/activity, number each page. Enter totals from line (05), columns (d), (e), and (f) to form HDS-1, block (04), columns (a), (b), and (c) in the appropriate row.

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY		FORM HDS-3
(01) Claimant	(02) Type of Claim Reimbursement ☐ Estimated ☐	Fiscal Year 19 ___/19 ___

(03) Reimbursable Components	
Assessment of Individuals With Exceptional Needs	
(a) Assessment: Interviews, Review of Records, Observations, Testing, etc.	
(b) Residential Placement: IEP Reviews, Case Management, and Expanded IEP	
(c) Related Services: Attendance at IEP meetings, Meeting with IEP Members and Parents, and Review of Independent Assessment.	
(d) Due Process Proceedings	
(e) Administrative Costs	
Mental Health Treatment	
(f) Treatment Services: Short-Doyle Program	
(g) Administrative Costs	
(04) Sub-total for Assessment of Individual with Exceptional Needs [Sum of (03), lines (a) to (e)]	
(05) Less: Amount Received from Short-Doyle/Medi-Cal (FFP only)	
(06) Less: Amount Received from State Categorical Funding	
(07) Less: Amount Received from Other (Identify)	
(08) Total for Assessment of Individual with Exceptional Needs [Line (04) minus the sum of lines (05) to (07)]	
(09) Sub-Total for Mental Health Treatment [block (03), lines (f) and (g)]	
(10) Less: Non-Categorical State General/Realignment Funds	
(11) Less: Amount Received from State Categorical Funds	
(12) Less: Amount Received from Short-Doyle/Medi-Cal (FFP only)	
(13) Less: Amount Received from Other (Identify)	
(14) Total Mental Health Treatment [Line (09) minus the sum of lines (10) to (13)]	
(15) Total Claimed Amount [Sum of line (08) and line (14)]	

SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY Instructions	FORM HDS-3

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form HDS-3 must be filed for a reimbursement claim. Do not complete form HDS-3 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form HDS-3 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Reimbursable Components. For each reimbursable component under block (03), lines (a), (b), and (c), enter the totals from form HDS-4, line (05) column (f), as applicable. For block (03), line (d), enter the cost from form HDS-5, line (08), if applicable. For block (03), lines (e) and (g), enter the cost from HDS-6, line (08), as appropriate.

(04) Sub-Total for Assessment of Individual with Exceptional Needs. Enter the sum of the amounts on block (03), lines (a), (b), (c), (d), and (e).

(05) Less: Amount Received from Short-Doyle/Medi-Cal (Federal Financial Participation only). From line 72, "Medi-Cal Federal", the Department of Mental Health Cost Reporting/Data Collection System, "Local Services Cost Report", form MH 1944, enter the sum of amounts shown for providers listed on form HDS-4, block (04)(a).

(06) Less: Amount Received from State Categorical Funding. Enter the total amount received from the State General Fund for special education.

(07) Less: Amount Received from Other (Identify). Enter the total amount received from sources which reimbursed the cost of this mandate (e.g., Patient health insurance, etc.). Attach a separate schedule identifying those funding sources.

(08) Total for Assessment of Individual with Exceptional Needs. Enter the result of subtracting the sum of lines (05), (06), and (07) from line (04).

(09) Sub-Total for Mental Health Treatment. Enter the sum of the amount from block (03), lines (f) and (g).

(10) Less: Non-Categorical State General/Realignment Funds.

(11) Less: Amount Received from State Categorical Funds. Enter the total amount received from the State General Fund for special education.

(12) Less: Amount Received from Short-Doyle/Medi-Cal (Federal Financial Participation only). From line 72 , "Medi-Cal Federal", the Department of Mental Health Cost Reporting/Data Collection System, "Local Services Cost Report", form MH 1944, enter the sum of amounts shown for providers listed on form HDS-4, block (04)(a).

(13) Less: Amount Received from Other (Identify). Enter the total amount received from sources which reimbursed the cost of this mandate (e.g., Patient health insurance). Attach a separate schedule identifying those funding.

(14) Total Mental Health Treatment. Enter the result of subtracting the sum of lines (10) to (13) from line (09).

(15) Total Claimed Amount. Enter the sum of line (08) and line (14). Carry forward the amount on this line to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL

FORM HDS-4

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Check **only** one box per form to identify the component being claimed

☐ Assessment

☐ Treatment Services

☐ Residential Placement

☐ Other (Identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I. D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total

(05) Total ☐ Subtotal ☐ Page:______of______

SERVICES TO HANDICAPPED STUDENTS COMPONENT/ACTIVITY COST DETAIL Instructions	FORM HDS-4

(01) Enter the name of the claimant.

(02) Enter the fiscal year of claim in which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form HDS-4 shall be prepared for each component which applies.

(04) Description of Expenses. For each "checked" component/activity box in block (03), enter the detailed costs for each case claimed.

(a) Enter the name of the provider.

(b) Enter the provider identification number.

(c) Enter the service function codes.

(d) Enter the number of units of service.

(e) Enter the rate per unit.

(f) Enter the total [multiply column (d) times column (e)]

A copy of that portion of the county's Short-Doyle fiscal year end report relating to the amounts claimed must be submitted with the claim.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed, or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

(05) Total line (04) column (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/activity costs, number each page. Carry forward the total from line (05) column (f) to form HDS-3, block (03) in the appropriate line.

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL

FORM HDS-5

(01) Claimant	(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Due Process Proceedings

(04) Description of Expenses: Complete columns (a) through (g).			Object Accounts			
(a) Employee Names, Job Classifications, Functions Performed and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Totals						
(05) Total Direct Costs						

Indirect Costs

(06) Indirect Cost Rate	[From ICRP]	%
(07) Total Indirect Costs	[Line (06) x line (05)(d)] or [Line (06) x {(05)(d) + (05)(e)}]	
(08) Total Direct and Indirect Costs	[Line (05) + line (07)]	

SERVICES TO HANDICAPPED STUDENTS COMPONENT/ACTIVITY COST DETAIL Instructions	FORM HDS-5

(01) Enter the name of the claimant.

(02) Enter the fiscal year in which costs were incurred.

(03) Reimbursable Components. Due Process Proceedings.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in line (03), enter the employee names, position titles, a brief description of their activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contracted services, etc. Total each column (d) through (g). **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed. If the descriptions are incomplete, the claim cannot be processed for payment.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns							Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	
Salaries	Employee Name Title Activities Performed	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked				
Benefits		Benefit Rate		Salaries	Benefits = Benefit Rate x Salaries			
Services and Supplies Office Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Consumed		
Contracted Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service				Itemized Cost of Services Performed	Invoice

(05) Total Direct Costs. Enter the total for columns (d) to (g).

(06) Indirect Cost Rate. Enter the indirect cost rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the department's Indirect Cost Rate Proposal (ICRP) for the program with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.

(07) Total Indirect Costs. Multiply Total Salaries, line (04)(d) by the Indirect Cost Rate, line (06). If both salaries and benefits are used in the distribution base for the computation of the indirect cost rate, then multiply Total Salaries, line (04)(d) and Total Benefits, line (04)(e) by the Indirect Cost Rate, line (06).

(08) Total Direct and Indirect Costs. Enter the sum of line (05) and line (07). Forward the amount to form HDS-1, line (03)(d).

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL

FORM HDS-6

(01) Claimant | (02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Administrative Costs

☐ Assessment of Individual ☐ Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).

(a) Employee Names, Job Classifications, Functions Performed and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	Object Accounts (d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Totals						

(05) Total Direct Costs	
Indirect Costs	
(06) Indirect Cost Rate [From ICRP]	%
(07) Total Indirect Costs [Line (06) x line (04)(d)] or [Line (06) x {(04)(d) + (04)(e)}]	

SERVICES TO HANDICAPPED STUDENTS COMPONENT/ACTIVITY COST DETAIL Instructions	FORM HDS-6

(01) Enter the name of the claimant.

(02) Enter the fiscal year in which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the administrative cost component (i.e., Assessment of Individuals or Mental Treatment) claimed. A separate form HDS-6 shall be prepared for administrative costs associated with the assessment of individuals with exceptional needs, and for mental health treatment.. Do not include indirect costs for line (03)(d), since the cost should be recorded on form HDS-5.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in line (03), enter the employee names, position titles, a brief description of their activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contracted services, etc. Total each column (d) through (g). **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed. If the descriptions are incomplete, the claim cannot be processed for payment.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns							Submit these supporting documents
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked				
Benefits	Title	Benefit Rate		Salaries	Benefits = Benefit Rate x			
Services and Supplies Office Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity		
Contracted Services	Name of Contractor Specific Tasks	Hourly Rate	Hours Worked Inclusive Dates of				Itemized Cost of Services Performed	Invoice

(05) Total Direct Costs. Enter the total for columns (d) to (g).

(06) Indirect Cost Rate. Enter the indirect cost rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the department's Indirect Cost Rate Proposal (ICRP) for the program with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.

(07) Total Indirect Costs. Multiply Total Salaries, line (04)(d) by the Indirect Cost Rate, line (06). If both salaries and benefits are used in the distribution base for the computation of the indirect cost rate, then multiply Total Salaries, line (04)(d) and Total Benefits, line (04)(e) by the Indirect Cost Rate, line (06). Forward the amount of indirect costs to form HDS-3, line (03)(e) or line (03)(g) as appropriate.

Exhibit B

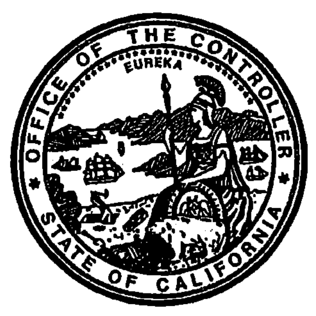
ORANGE COUNTY

Audit Report

HANDICAPPED AND DISABLED STUDENTS PROGRAM

Chapter 1747, Statutes of 1984,
and Chapter 1274, Statutes of 1985

July 1, 2000, through June 30, 2002



JOHN CHIANG
California State Controller

March 2007

JOHN CHIANG
California State Controller

March 30, 2007

Honorable David E. Sundstrom, CPA
Auditor-Controller
Orange County
12 Civic Center Plaza, Room 202
Santa Ana, CA 92702

Dear Mr. Sundstrom:

The State Controller's Office audited the costs claimed by Orange County for the legislatively mandated Handicapped and Disabled Students Program (Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985) for the period of July 1, 2000, through June 30, 2002.

The county claimed $32,132,972 for the mandated program. Our audit disclosed that $26,241,767 is allowable and $5,891,205 is unallowable. The unallowable costs occurred because the county overstated administrative costs, understated offsetting revenues, and understated assessment and treatment costs. The State paid the county $18,222,464. Allowable costs claimed exceed the amount paid by $8,019,303.

If you disagree with the audit findings, you may file an Incorrect Reduction Claim (IRC) with the Commission on State Mandates (COSM). The IRC must be filed within three years following the date that we notify you of a claim reduction. You may obtain IRC information at COSM's Web site, at www.csm.ca.gov (Guidebook link); you may obtain IRC forms by telephone, at (916) 323-3562, or by e-mail, at csminfo@csm.ca.gov.

If you have any questions, please contact Jim L. Spano, Chief, Compliance Audits Bureau, at (916) 323-5849.

Sincerely,

JEFFREY V. BROWNFIELD
Chief, Division of Audits

JVB/vb

cc: Honorable David E. Sundstrom, CPA
Auditor-Controller
Orange County
Mark A. Refowitz, Deputy Agency Director
Behavioral Health Services
Health Care Agency
Orange County
Howard Thomas, Health Care Agency Accounting Manager
Orange County
Todd Jerue, Program Budget Manager
Corrections and General Government
Department of Finance
Robin Ulesich-Foemmel
Special Education Program
Department of Mental Health
Cynthia Wong, Manager
Special Education Division
California Department of Education

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Attachment—County's Response to Draft Audit Report

Audit Report

Summary

The State Controller's Office (SCO) audited the costs claimed by Orange County for the legislatively mandated Handicapped and Disabled Students Program (Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985) for the period of July 1, 2000, through June 30, 2002. The last day of fieldwork was April 28, 2005.

The county claimed $32,132,972 for the mandated program. Our audit disclosed that $26,241,767 is allowable and $5,891,205 is unallowable. The unallowable costs occurred because the county overstated administrative costs, understated offsetting revenues, and understated assessment and treatment costs. The State paid the county $18,222,464. Allowable costs claimed exceed the amount paid by $8,019,303.

Background

Chapter 26 of the *Government Code,* commencing with Section 7570, and *Welfare and Institutions Code* Section 5651 (added and amended by Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985) require counties to participate in the mental health assessment for "individuals with exceptional needs," participate in the expanded "Individualized Education Program" (IEP) team, and provide case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed." These requirements impose a new program or higher level of service on counties.

On April 26, 1990, the Commission on State Mandates (COSM) determined that this legislation imposed a state mandate reimbursable under *Government Code* Section 17561.

Parameters and Guidelines establishes the state mandate and defines reimbursement criteria. The COSM adopted the *Parameters and Guidelines* for the Handicapped and Disabled Students Program on August 22, 1991, and last amended it on August 29, 1996. In compliance with *Government Code* Section 17558, the SCO issues claiming instructions for mandated programs, to assist local agencies and school districts in claiming reimbursable costs.

Parameters and Guidelines for the Handicapped and Disabled Students Program state that only 10% of mental health treatment costs are reimbursable. However, on September 30, 2002, Assembly Bill 2781 (Chapter 1167, Statutes of 2002) changed the regulatory criteria by stating that the percentage of treatment costs claimed by counties for fiscal year (FY) 2000-01 and prior fiscal years is not subject to dispute by the SCO. Furthermore, this legislation states that, for claims filed in FY 2001-02 and thereafter, counties are not required to provide any share of these costs or to fund the cost of any part of these services with money received from the Local Revenue Fund established by *Welfare and Institutions Code* Section 17600 et seq. (realignment funds).

Furthermore, Senate Bill 1895 (Chapter 493, Statutes of 2004) states that realignment funds used by counties for the Handicapped and Disabled Students Program "are eligible for reimbursement from the state *for all*

allowable costs to fund assessments, psychotherapy, and other mental health services..." and that the finding by the Legislature is "declaratory of existing law." (Emphasis added.)

On May 26, 2005, the COSM adopted a *Statement of Decision* for the Handicapped and Disabled Students II Program that incorporates the above legislation and further identifies medication support as a reimbursable cost effective July 1, 2001. The COSM adopted the *Parameters and Guidelines* for this new program on December 9, 2005, and made technical corrections to it on July 21, 2006. *Parameters and Guidelines* for the Handicapped and Disabled Students II Program states that "Some costs disallowed by the State Controller's Office in prior years are now reimbursable beginning July 1, 2001 (e.g., medication monitoring). Rather than claimants re-filing claims for those costs incurred beginning July 1, 2001, the State Controller's Office will reissue the audit reports." Consequently, we are allowing medication support costs commencing on July 1, 2001.

Objective, Scope, and Methodology

We conducted the audit to determine whether costs claimed represent increased costs resulting from the Handicapped and Disabled Students Program for the period of July 1, 2000, through June 30, 2002.

Our audit scope included, but was not limited to, determining whether costs claimed were supported by appropriate source documents, were not funded by another source, and were not unreasonable and/or excessive.

We conducted the audit according to *Government Auditing Standards*, issued by the Comptroller General of the United States, and under the authority of *Government Code* Sections 12410, 17558.5, and 17561. We did not audit the county's financial statements. We limited our audit scope to planning and performing audit procedures necessary to obtain reasonable assurance that costs claimed were allowable for reimbursement. Accordingly, we examined transactions, on a test basis, to determine whether the costs claimed were supported.

We limited our review of the county's internal controls to gaining an understanding of the transaction flow and claim preparation process as necessary to develop appropriate auditing procedures.

Conclusion

Our audit disclosed instances of noncompliance with the requirements outlined above. These instances are described in the accompanying Summary of Program Costs (Schedule 1) and in the Findings and Recommendations section of this report.

For the audit period, Orange County claimed $32,132,972 for costs of the Handicapped and Disabled Students Program. Our audit disclosed that $26,241,767 is allowable and $5,891,205 is unallowable.

For the FY 2000-01 claim, the State paid the county $9,511,041. Our audit disclosed that $6,940,136 is allowable. The State will offset $2,570,905 from other mandated program payments due to the county. Alternatively, the county may remit this amount to the State.

For the FY 2001-02 claim, the State paid the county $8,711,423. Our audit disclosed that $19,301,631 is allowable. The State will pay allowable costs claimed that exceed the amount paid, totaling $10,590,208, contingent upon available appropriations.

Views of Responsible Officials

We issued a draft audit report on October 27, 2006. Benjamin P. de Mayo, County Counsel, responded by letter dated November 14, 2006 (Attachment), disagreeing with the audit results. This final audit report includes the county's response.

Restricted Use

This report is solely for the information and use of Orange County, and the SCO; it is not intended to be and should not be used by anyone other than these specified parties. This restriction is not intended to limit distribution of this report, which is a matter of public record.

JEFFREY V. BROWNFIELD
Chief, Division of Audits

Schedule 1—
Summary of Program Costs
July 1, 2000, through June 30, 2002

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustment	Reference[1]
July 1, 2000, through June 30, 2001				
Assessment/case management costs	$ 5,426,476	$ 4,895,673	$ (530,803)	Finding 3
Administrative costs	2,516,904	1,648,944	(867,960)	Finding 1
Offsetting revenues:				
State categorical funds	(329,822)	(409,436)	(79,614)	Finding 2
Short-Doyle/Medi-Cal funds	—	(624,993)	(624,993)	Finding 2
Other	—	—	—	
Net assessment/case management costs	7,613,558	5,510,188	(2,103,370)	
Treatment costs	9,223,879	6,933,272	(2,290,607)	Finding 3
Administrative costs	3,409,319	2,053,402	(1,355,917)	Finding 1
Offsetting revenues:				
State general/realignment funds	(5,998,426)	(5,998,426)	—	
State categorical funds	(699,001)	(885,473)	(186,472)	Finding 2
Short-Doyle/Medi-Cal funds	(625,439)	(580,278)	45,161	Finding 2
Other	(92,549)	(92,549)	—	
Net treatment costs	5,217,783	1,429,948	(3,787,835)	
Subtotal	$ 12,831,341	6,940,136	$ (5,891,205)	
Less allowable costs that exceed claimed costs[2]		—		
Total program costs		6,940,136		
Less amount paid by the State		(9,511,041)		
Allowable costs claimed in excess of (less than) amount paid		$ (2,570,905)		
July 1, 2001, through June 30, 2002				
Assessment/case management costs	$ 5,407,140	$ 7,021,087	$ 1,613,947	Finding 3
Administrative costs	3,209,823	2,549,043	(660,780)	Finding 1
Offsetting revenues:				
State categorical funds	(933,938)	(533,817)	400,121	Finding 2
Short-Doyle/Medi-Cal funds	—	(745,974)	(745,974)	Finding 2
Other	—	—	—	
Net assessment/case management costs	7,683,025	8,290,339	607,314	
Treatment costs	9,544,249	11,710,936	2,166,687	Finding 3
Administrative costs	4,526,546	3,715,094	(811,452)	Finding 1
Offsetting revenues:				
State general/realignment funds	—	—	—	
State categorical funds	(699,001)	(1,193,541)	(494,540)	Finding 2
Short-Doyle/Medi-Cal funds	(1,660,639)	(928,157)	732,482	Finding 2
Other	(92,549)	(92,549)	—	

Schedule 1 (continued)

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustment	Reference [1]
July 1, 2001, through June 30, 2002 (continued)				
Net treatment costs	11,618,606	13,211,783	1,593,177	
Subtotal	$ 19,301,631	21,502,122	$ 2,200,491	
Less allowable costs that exceed claimed costs [2]		(2,200,491)		
Total program costs		19,301,631		
Less amount paid by the State		(8,711,423)		
Allowable costs claimed in excess of (less than) amount paid		$ 10,590,208		
Summary: July 1, 2000, through June 30, 2002				
Assessment/case management costs	$ 10,833,616	$ 11,916,760	$ 1,083,144	Finding 3
Administrative costs	5,726,727	4,197,987	(1,528,740)	Finding 1
Offsetting revenues:				
State categorical funds	(1,263,760)	(943,253)	320,507	Finding 2
Short-Doyle/Medi-Cal funds	—	(1,370,967)	(1,370,967)	Finding 2
Other	—	—	—	
Net assessment/case management costs	15,296,583	13,800,527	(1,496,056)	
Treatment costs	18,768,128	18,644,208	(123,920)	Finding 3
Administrative costs	7,935,865	5,768,496	(2,167,369)	Finding 1
Offsetting revenues:				
State general/realignment funds	(5,998,426)	(5,998,426)	—	
State categorical funds	(1,398,002)	(2,079,014)	(681,012)	Finding 2
Short-Doyle/Medi-Cal funds	(2,286,078)	(1,508,435)	777,643	Finding 2
Other	(185,098)	(185,098)	—	
Net treatment costs	16,836,389	14,641,731	(2,194,658)	
Subtotal	$ 32,132,972	28,442,258	$ (3,690,714)	
Less allowable costs that exceed claimed costs [2]		(2,200,491)		
Total program costs		26,241,767		
Less amount paid by the State		(18,222,464)		
Allowable costs claimed in excess of (less than) amount paid		$ 8,019,303		

[1] See the Findings and Recommendations section.

[2] *Government Code* Section 17561 stipulates that the State will not reimburse any claim more than one year after the filing deadline specified in the SCO's claiming instructions. That deadline has expired for FY 2000-01 and FY 2001-02.

Findings and Recommendations

FINDING 1— Overstated administrative costs

The county miscalculated its administrative costs. The county used incorrect unit information from preliminary reports to allocate administrative costs to the mandate. The county also did not apply any administrative revenues, even though it received Short Doyle/ Medi-Cal Federal Financing Participation funds.

We recalculated the administrative costs allocation using the correct units of service and applying all relevant administrative revenues. The recalculation resulted in an overstatement of administrative costs of $2,223,877 and $1,472,232 for fiscal year (FY) 2000-01 and FY 2001-02, respectively.

Parameters and Guidelines for the program specifies that administrative costs incurred in the performance of the mandated activities and adequately documented are reimbursable.

Parameters and Guidelines further specifies that reimbursable indirect costs may be claimed to the extent that they have not already been reimbursed by the State Department of Mental Health from categorical funding sources.

Audit adjustments result from the use of actual units and the application of offsetting revenues as follows.

	Fiscal Year		
	2000-01	2001-02	Total
Assessment	$ (867,960)	$ (660,780)	$ (1,528,740)
Treatment	(1,355,917)	(811,452)	(2,167,369)
Audit adjustment	$ (2,223,877)	$ (1,472,232)	$ (3,696,109)

Recommendation

We recommend that, when preparing its administrative cost allocation, the county ensures that the correct units of service are used and that all relevant offsetting revenues are applied to reduce administrative costs.

County's Response

The county did not respond to this finding.

SCO's Comment

The finding remains unchanged.

FINDING 2— Understated offsetting revenues

The county used preliminary reports to compute offsetting revenues. The county used the units from these preliminary reports to compute offsetting revenues. Once the reconciliation was finalized, the information was not corrected on the claims. Additionally, the county did not include Early Periodic Screening Diagnosis and Treatment (EPSDT).

We recalculated the offsetting revenues by using the correct units and costs per unit, including all relevant revenues. The county understated offsetting revenues by $845,918 and $107,911 in FY 2000-01 and FY 2001-02, respectively. The overstatement relative to treatment in the last fiscal year is due to the overstatement of units and the application of an incorrect funding percentage for Short Doyle/ Medi-Cal Federal Financing Participation. The calculations exclude revenues related to the unallowable costs discussed in Finding 3.

Parameters and Guidelines specifies that any direct payments received from the State that are specifically allocated to the program, and any other reimbursement received as a result of the mandate from any source, must be deducted from the claim.

By excluding EPSDT funds and not allocating revenues based on actual services provided, the county misstated its offsetting revenues as follows.

	Fiscal Year		
	2000-01	2001-02	Total
Assessment	$ (704,607)	$ (345,853)	$ (1,050,460)
Treatment	(141,311)	237,942	96,631
Audit adjustment	$ (845,918)	$ (107,911)	$ (953,829)

Recommendation

We recommend that the county implement policies and procedures to ensure that all applicable reimbursements are offset against reimbursable costs incurred for this program. Further, we recommend that the county calculate applicable reimbursements based on actual units of service provided for a particular program.

County's Response

The county did not respond to this finding.

SCO's Comment

The finding remains unchanged.

FINDING 3— Understated assessment and treatment costs

The claimed costs were not based on actual costs to implement the mandated program. The county used preliminary unit reports to prepare its claims. The county produced the unit reports while the cost report reconciliation was in process. These amounts remained uncorrected once the finalization of the cost reports was complete. In some cases, the county applied an incorrect cost per unit to determine costs. The county also included ineligible medication monitoring services (FY 2000-01 only), crisis intervention, and therapeutic behavioral services. Audit adjustments reflect the changes due to the adoption of the Handicapped and Disabled Students II Program.

We determined allowable costs based on actual units of eligible services, using the appropriate unit cost representing the actual cost to the county. Our calculation resulted in an overstatement of $2,821,410 and an understatement of $3,780,634 for FY 2000-01 and FY 2001-02, respectively.

Parameters and Guidelines for the program specifies that only actual increased costs incurred in the performance of the mandated activities and adequately documented are reimbursable.

Parameters and Guidelines specifies that only the following treatment services are reimbursable: individual therapy, collateral therapy and contacts, group therapy, day treatment, and the mental health portion of residential treatment in excess of California Department of Social Services payments for residential placement.

On December 9, 2005, the COSM adopted the *Parameters and Guidelines* for the Handicapped and Disabled Students II Program. Under this program, medication support is a reimbursable cost. The reimbursement period for the program begins FY 2001-02; therefore, the audit adjustments below do not include medication support costs for FY 2001-02.

Because the county claimed costs that are not based on actual units and costs per unit and claimed ineligible services, it misstated its claims as follows.

	Fiscal Year		
	2000-01	2001-02	Total
Assessment	$ (530,803)	$ 1,613,947	$ 1,083,144
Treatment	(2,290,607)	2,166,687	(123,920)
Audit adjustment	$ (2,821,410)	$ 3,780,634	$ 959,224

Recommendation

We recommend that the county implement policies and procedures to ensure that it utilizes the actual unit-of-service cost per unit and claims only eligible services in accordance with the mandated program.

County's Response

The county did not respond to this finding.

SCO's Comment

The finding remains unchanged.

FINDING 4—
Lawsuit-Related Issue

In its response, the county stated that it will not return the $2,570,905 in audit adjustments as a result of a lawsuit it brought against the State. The county believes that the unreimbursed mandated costs it is due from the State for FY 1995-96 through and including FY 2003-04 have been set by the court. Therefore, the county believes that the audit has no legal bearing. The county's response and the SCO's comment are as follows.

County's Response

> This office is writing on behalf of the Orange County Auditor-Controller, David E. Sundstrom, in response to the October 27, 2006, correspondence from Jeffrey V. Brownfield and the above referenced Audit Report. Mr. Brownfield's letter indicates any response to the audit should be directed to your attention. We wish to advise you that the Auditor-Controller will not be returning $2,570,905 to the State as recommended in the "Conclusion" of the Audit Report.
>
> You may or may not be aware of a lawsuit that the County of Orange instituted against the State of California, the State Controller, and the State Treasurer in April 2004. The County of Orange was a Plaintiff as was the County of San Diego in the case of *County of San Diego and County of Orange v. State of California et al.*, San Diego Superior Court case number GIC 825109 (consolidated with GIC 827845). At issue in the lawsuit were unreimbursed mandated costs for fiscal years 1995-96 through and including 2003-04. After a trial on the merits in December 2005, judgment was entered in favor of the Counties. The judgment set the sum total of unreimbursed mandated costs owing the County of Orange in the amount of $72,755,977. See attachment A, a true and correct copy of the judgment.
>
> The $72,755,977 is comprised of 41 different state mandated programs including the program that is the subject of the Audit Report. Attachment B is a true and correct copy of what was an Exhibit at trial, reflecting the various state mandated programs and corresponding amounts to which the Attorney General's Office, on behalf of the State Defendants, stipulated were due and owing the County of Orange, and not in dispute at trial. As item 30 on page three of Attachment B reflects, the Court's judgment set the amount owing the County of Orange for "Handicapped and Disabled Students Program" at $3,320,300 for fiscal year 2000-01 and $10,590,208 for fiscal year 2001-02. Attachment C is a true and correct copy of relevant pages from the "Joint Trial Readiness Conference Report" that was filed with the Court in November 2005, demonstrating the stipulation of the parties. Attachment D is a true and correct copy of relevant pages of the Court's statement of decision which formed the basis for the judgment in favor of the Counties. As Attachments C and D reflect, the State's attorneys agreed to the amounts reflected in Attachment B as due and owing the County of Orange, and Judgment was entered accordingly.
>
> Since the amount of money that the County of Orange is due from the State for unreimbursed state mandated program costs has been set by a court of law, the issue is *res judicata* and the audit has no legal bearing. Therefore, the County of Orange will not be returning $2,570,905 to the State. Please feel free to contact the undersigned with any questions or concerns. If you prefer to discuss the issue with the State's attorney, Leslie Lopez, Deputy Attorney General was the trial attorney – (916) 327-0973.

SCO's Comment

We believe that the audit is valid and has legal bearing.

During the discovery for the aforementioned case, the State admitted that the county filed claims in a given amount and that the State has made partial payment. Neither the State nor the court stated that the claims were final and not subject to an SCO audit pursuant to *Government Code* Sections 12410, 17558.5, and 17561. Further, the matter is currently in appeal and, therefore, is not *res judicata*.

For the FY 2000-01 claim, we updated the conclusion section of this report to indicate that the State will offset $2,570,905 from other mandated program payments due to the county. We further stated that, as an alternative, the county may remit the amount to the State. Previously, the report stated that the county should return $2,579,905 to the State.

Attachment—
County's Response to
Draft Audit Report

OFFICE OF
THE COUNTY COUNSEL
COUNTY OF ORANGE
10 CIVIC CENTER PLAZA
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Writer's Direct Dial Number
(714) 834-6298

November 14, 2006

Jim L. Spano, Chief
Compliance Audits Bureau
California State Controller's Office
Division of Audits
Post Office Box 942850
Sacramento, CA 94250-5874

Re: Orange County Audit Report Handicapped and Disabled Students Program
July 1, 2000 – June 30, 2002

Dear Mr. Spano:

This office is writing on behalf of the Orange County Auditor-Controller, David E. Sundstrom, in response to the October 27, 2006, correspondence from Jeffrey V. Brownfield and the above referenced Audit Report. Mr. Brownfield's letter indicates any response to the audit should be directed to your attention. We wish to advise you that the Auditor-Controller will not be returning $2,570,905 to the State as recommended in the "Conclusion" of the Audit Report.

You may or may not be aware of a lawsuit that the County of Orange instituted against the State of California, the State Controller, and the State Treasurer in April 2004. The County of Orange was a Plaintiff as was the County of San Diego in the case of *County of San Diego and County of Orange v. State of California et al.*, San Diego Superior Court case number GIC 825109 (consolidated with GIC 827845). At issue in the lawsuit were unreimbursed mandated costs for fiscal years 1995-96 through and including 2003-04. After a trial on the merits in December 2005, judgment was entered in favor of the Counties. The judgment set the sum total of unreimbursed mandated costs owing the County of Orange in the amount of $72,755,977. See attachment A, a true and correct copy of the judgment.

The $72,755,977 is comprised of 41 different state mandated programs including the program that is the subject of the Audit Report. Attachment B is a true and correct copy of what was an Exhibit at trial, reflecting the various state mandated programs and corresponding amounts to which the Attorney General's Office, on behalf of the State Defendants, stipulated were due and owing the County of Orange, and not in dispute at trial. As item 30 on page three of Attachment B reflects, the Court's judgment set the amount owing the County of Orange for "Handicapped and Disabled Students Program" at $3,320,300 for fiscal year 2000-01 and

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$10,590,208 for fiscal year 2001-02. Attachment C is a true and correct copy of relevant pages from the "Joint Trial Readiness Conference Report" that was filed with the Court in November 2005, demonstrating the stipulation of the parties. Attachment D is a true and correct copy of relevant pages of the Court's statement of decision which formed the basis for the judgment in favor of the Counties. As Attachments C and D reflect, the State's attorneys agreed to the amounts reflected in Attachment B as due and owing the County of Orange, and Judgment was entered accordingly.

Since the amount of money that the County of Orange is due from the State for unreimbursed state mandated program costs has been set by a court of law, the issue is *res judicata* and the audit has no legal bearing. Therefore, the County of Orange will not be returning $2,570,905 to the State. Please feel free to contact the undersigned with any questions or concerns. If you prefer to discuss the issue with the State's attorney, Leslie Lopez, Deputy Attorney General was the trial attorney – (916) 327-0973.

Very truly yours,

BENJAMIN P. de MAYO
COUNTY COUNSEL

By [signature]
Wendy J. Phillips, Deputy

WJP:mll

cc: David Sundstrom, Orange County Auditor-Controller
Alice Sworder, Senior Manager, HCA Accounting, Office of the Auditor-Controller
Leslie Lopez, Deputy Attorney General

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ATTACHMENT A

FILED
Clerk of the Superior Court
MAY 12 2006
By: L. ROCKWELL, Deputy

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8 IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
9 IN AND FOR THE COUNTY OF SAN DIEGO

10 COUNTY OF SAN DIEGO, 11 Plaintiff/Petitioner, 12 v. 13 STATE OF CALIFORNIA; STEVE WESTLY in his official capacity as California State Controller; PHIL ANGELIDES in his official capacity as California State Treasurer; DONNA ARDUIN in her official capacity as Director of the California State Department of Finance; and DOES 1 through 50, inclusive, 17 Defendants/Respondents.	Case No. GIC 825109 (consolidated with Case No. GIC 827845) JUDGMENT (~~PROPOSED~~) Trial Date: November 28,2005 Time: 10:30 a.m. Dept: 70 I/C Judge: Honorable Jay M. Bloom Actions filed: 2/3/04 and 4/1/04

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1 COUNTY OF ORANGE,
2 Plaintiff/Petitioner,
3 v.
4 STATE OF CALIFORNIA; STEVE WESTLY in his official capacity as California
5 State Controller; PHIL ANGELIDES in his official capacity as California State Treasurer;
6 DONNA ARDUIN in her official capacity as Director of the California State Department of
7 Finance; and DOES 1 through 50, inclusive,
8 Defendants/Respondents.
9

10 Plaintiffs/Petitioners County of San Diego's and County of Orange's consolidated
11 complaints for declaratory relief and petitions for issuance of a writ of mandate came on for trial
12 on November 28,2005, at 10:30 am., in Department 70 of the above-entitled court, the
13 Honorable Jay M. Bloom, judge presiding. The County of San Diego was represented by John
14 J. Sansone, County Counsel by Timothy M. Barry, Senior Deputy. The County of Orange was
15 represented by Benjamin P. de Mayo, County Counsel by Wendy J. Phillips, Deputy County
16 Counsel. The State of California, California State Controller, California State Treasurer, and
17 Director of the California State Department of Finance, were represented by William Lockyer,
18 Attorney General by Leslie R. Lopez, Deputy Attorney General.
19 Having heard and considered the evidence both written and oral and the oral arguments
20 of counsel for the parties it is hereby ORDERED, AJUDGED and DECREED as follows:
21 1. The State of California is obligated to reimburse the County of San Diego and the
22 County is entitled to judgment in the total principal sum of $41,652,974 for the balance due on
23 its claims for costs incurred in providing State mandated programs and services from fiscal year
24 1994-95 through fiscal year 2003-04, together with interest thereon at the legal rate of seven
25 ////
26 ////
27 ////
28 ////

JUDGMENT ~~(PROPOSED)~~

percent (7%) per annum from February 3,2004. Interest on the $41,652,974 at the legal rate from February 3,2004, through May 10,2006 (826 days), the date of entry of this judgment, is $6,328,236 for a total judgment of $47,981,210.

2. The State of California is obligated to reimburse the County of Orange and the County is entitled to judgment in the total principal sum of $72,755,977 for the balance due on its claims for costs incurred in providing State mandated programs and services from fiscal year 1994-95 through fiscal year 2003-04, together with interest at the legal rate of seven percent (7%) per annum from April 1,2004. Interest on the $72,755,977 at the legal rate from April 1, 2004, through May 10,2006 (770 days), the date of entry of this judgment, is $9,982,132 for a total judgment of $82,738,109.

3. The Counties request for pre-petition interest is denied.

4. A writ of mandate pursuant to Code of Civil Procedure section 1084, et seq. shall issue commanding respondents, State of California, State Controller, State Treasurer, and Director of the California State Department of Finance to pay the amount of the judgment plus interest to the County of San Diego and the County of Orange over the fifteen year period required by Government Code section 17617 (or a shorter period if the Legislature enacts a shorter period, elects to pay the debt off earlier or is otherwise required by law to pay the debt off over a shorter period) in equal annual installments beginning with the budget for the 2006-07 fiscal year and annually thereafter each successive budget until paid.

5. Respondents will file a return on the writ with the court within 90 days of the enactment of the State budget for each fiscal year commencing with the 2006-07 fiscal year demonstrating compliance with the writ until the amounts owed have been fully paid.

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1 6. This court will retain jurisdiction to enforce the writ in the event respondents fail
2 to comply with the writ.
3 7. Petitioners/plaintiffs are awarded costs of suit in the amount of $________
4
5 DATED: MAY 1 2 2006 JAY M. BLOOM
JUDGE OF THE SUPERIOR COURT
6
7 APPROVED AS TO FORM AND CONTENT,
8 BILL LOCKYER, Attorney General
9
By LESLIE R. LOPEZ, Deputy Attorney General
10 for Defendants State Of California, Steve Westly,
11 Phil Angelides, and Tom Campbell
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ATTACHMENT B

Claims Summary - Orange County

	BUDGET ITEM - STATE DEPARTMENT Mandate	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03	FY 03-04	[illegible]
	Item 0450-295-0001 State Trial Court Funding											
1	Grand Jury Proceeding (Ch 1170/96)									22,572	7,921	
	Item 0690-295-0001 Office of Emergency Services											
2	Crime Victims' Rights (Ch 411/95) (Previously 8100-295-0001 Off. Of Crm Justice)								17,044	16,964		
3	Sex Crimes Confidentiality (Ch 502/92)				13,848	14,276	15,237	14,646	14,749	17,649		
	Item 0820 295-0001 Department of Justice											
4	Booking & Fingerprinting (Ch 1105/92)							947				
5	Child Abduction and Recovery (Ch 1399/76)							144,508	171,935	584,528	516,632	
6	Sex Offenders Disclosure By Law Enforcement Officers (Megan's Law) - (Local Agencies) (Ch 908/96)			10,067	295,206	368,974	401,231	441,988	438,597	448,889		
7	Stolen Vehicle Notification (Ch 337/90)											
	Item 0890 295-0001 Secretary of State											
8	Absentee Ballots (Local Agency) (Ch 77/78 and Ch 920/94)							401,436	348,334	573,375	891,366	
9	Absentee Ballots: Tabulation by Precinct (Ch 697/99)							2,979				

Revised 11/8/2006

Claims Summary - Orange County

	BUDGET ITEM - STATE DEPARTMENT Mandate	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03	FY 03-04
10	Permanent Absent Voters (Ch 1422/82)								86,663	91,815	45,754
11	Presidential Primaries 2000 (Ch 18/99)						26,176				
12	Voter Registration Procedures (Ch 704/75)								38,150	41,950	89,864
	Item 0950-295-0001 State Treasurer										
13	County Treasury Oversight Comm. (Ch 784/95)		6,530	22,496	41,910	55,775	51,664	61,407	65,363	105,617	
14	Investment Reports (Local Agencies) (Ch 783/95)									452,471	
	Item 1880-295-0001 State Personnel Board										
15	Police Officers Procedural Bill Of Rights (Ch 465/76)	417,968	434,219	775,948	451,726	384,219	315,388	341,751	508,494	513,301	654,990
	Item 2740-295-0044 Department of Motor Vehicles										
16	Administrative License Suspension (Ch 1460/89)						1,570	2,189	1,569	1,815	1,761
	Item 4260-295-0001 Department of Health Services										
17	Aids Testing (Ch 1597/88)								1,126	46,843	
18	Medical-Cal Death Notices (Ch 102/81)								6,181	8,441	5,085
19	Pacific Beach Safety (Ch 961/92)										
20	Search Warrant: Aids (Ch 1088/88)										

Revised 11/8/2006

Claims Summary - Orange County

	BUDGET ITEM - STATE DEPARTMENT Mandate	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03	FY 03-04	[illegible]
21	SIDS: Autopsy Protocols (Ch 955/89)								2,498	82,939		[illegible]
22	SIDS: Contact By Local Health Officers (Ch 268/91)									30,985		[illegible]
	Item 4300-295-0001 Department of Developmental Services											
23	Conservatorship (Ch 1304/80)									5,600	5,928	[illegible]
24	Developmentally Disabled: Attorney Services (Ch 694/75)								25,337	121,334	123,265	[illegible]
25	SMAS Mentally Retarded: Diversion (Ch 1253/80)									3,809	4,325	[illegible]
	Item 4440 295-0001 Department of Mental Health											
26	MDSO (Mentally Disordered Sex Offenders) Recommitments (Ch 1036/78)								4,758	17,665	21,183	[illegible]
27	Mentally Disordered Offenders' Extended Commitment Proceedings (Ch 1418/85)				5,359	9,207	14,699	76,672	82,777	152,136	102,479	[illegible]
28	Not Guilty By Reason Of Insanity (Ch 1114/79 and Ch 650/82)				127,307				255,800	126,771	93,786	[illegible]
29	Seriously Emotionally Disturbed Pupils: Out-Of-State Mental Health Services (Ch 654/96)				53,524	63,355	53,099	1,191,638	1,538,794	1,692,038	1,497,554	[illegible]
30	Services to Handicapped and Disabled Students (Ch 1747/84 and Ch 1274/85)						4,895,541	3,320,300	10,590,208	20,223,066	7,581,073	[illegible]

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Revised 11/8/2006

Claims Summary - Orange County

	BUDGET ITEM - STATE DEPARTMENT Mandate	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03	FY 03-04
31	Sexually Violent Predators (Ch 762 and 763, Statutes of 1995)								619,630	1,310,550	1,016,836
32	SMAS Coroners (Ch 498/77)									15,170	16,134
	Item 5180-295-0001 Department of Social Services										
33	Child Abuse Treatment Services Authorization And Case Management (Ch 1090/96)										
	Item 5240-295-0001 Department of Corrections										
34	Prisoner Parental Rights (Ch 820/91)								227,010	652,104	304,142
	Item 5430-295-0001 Board of Corrections										
35	Domestic Violence Treatment Services Authorization And Case Management (Ch 183/92)								54,876	281,552	318,814
	Item 5460-295-0001 Department of Youth Authority										
36	Extended Commitment - Youth Authority (Ch 546/84 & 267/98)						3,944	7,483	1,132		
	Item 7350-295-0001 Department of Industrial Relations (Previously Item 8350-295-0001)										
37	Peace Officer's Cancer Presumption (Ch 1171/89)								1,239	2,132	1,872

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Revised 11/8/2006

Claims Summary - Orange County

	BUDGET ITEM - STATE DEPARTMENT Mandate	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03	FY 03-04	[illegible]
	Item 8120-295-0001 Commission on Peace Officer Standards and Training											
38	Domestic Violence Arrest Policies And Standards (Ch 246/95)								15,598	22,456	21,966	
39	Law Enforcement Sexual Harassment Training (Ch 126/93)						1,043					
	Item 8570-295-0001 Department of Food and Agriculture											
40	Animal Adoptions (Ch 752/98)					2,205	31,446	63,175	22,600	17,422		
	Item 9100-295-0001 Local Assistance - Tax Relief											
41	Allocation of Property Tax Revenue: Educational Revenue Augmentation Funds (Ch 697/92)								122			
42	Redevelopment Agencies – Tax Disbursement Reporting (Ch 39/98)					2,182	2,249	2,361	2,459	2,513	2,580	
43	Senior Citizens' Property Tax Deferral Program (Ch 1242/77)									14,759	15,569	
44	Unitary Countywide Tax Rate (Ch 921/87)											
	Item 9210-295-0001 Local Government Financing											
45	Health Benefits For Survivors Of Peace Officers And Firefighters (Local Agencies) (Ch 1120/96)											

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Revised 11/8/2006

Claims Summary - Orange County

	BUDGET ITEM - STATE DEPARTMENT Mandate	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03	FY 03-04	[illegible]
46	Mandate Reimbursement Process (Ch 486/75)							238,241	164,785	188,444	197,642	[illegible]
47	Open Meetings (Ch 641/86)				11,389	11,489	12,459	20,765	77,668	87,432	112,381	[illegible]
48	Rape Victim Counseling Center Notices (Ch 999/91 and Ch 224/92)											[illegible]
49	Mentally Disordered Sex Offenders: Extended Commitments (Ch 991/79).											[illegible]
	Item No. 2660-1020890 Dept. of Transportation (FY 05-06) - Gov. line itemed vetoed appropriation											[illegible]
50	Regional Housing Needs (1143/80)									5,061	0	[illegible]
												72,755,977
	TOTAL	417,968	440,749	808,511	1,000,269	911,682	5,825,746	6,332,486	15,385,496	27,982,168	13,650,902	72,755,977

6

Revised 11/8/2006

ATTACHMENT C

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BENJAMIN P. de MAYO, County Counsel
7 County of Orange
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Santa Ana, California 92702-1379
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Facsimile: (714) 834-2359
11
Attorneys for Plaintiff/Petitioner County of Orange
12

13 **IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA**

14 **IN AND FOR THE COUNTY OF SAN DIEGO**

15 COUNTY OF SAN DIEGO,

16 Plaintiff/Petitioner,

17 v.

18 STATE OF CALIFORNIA; STEVE WESTLY in his official capacity as California
19 State Controller; PHIL ANGELIDES in his official capacity as California State Treasurer;
20 DONNA ARDUIN in her official capacity as Director of the California State Department of
21 Finance; and DOES 1 through 50, inclusive,

22 Defendants/Respondents.

Case No. GIC 825109 (consolidated with Case No. GIC 827845
[Actions filed: 2/3/04 and 4/1/04]

JOINT TRIAL READINESS CONFERENCE REPORT

Trial Readiness Conference
Date: November 18, 2005
Time: 1:30 p.m.
Dept: 70

Trial Date: November 23, 2005
Trial Time Estimate:
Jury Requested: No
Jury Fee Deposited: N/A
Court Reporter Requested: Yes

I/C Judge: Honorable Jay M. Bloom

Actions filed: 2/3/04 and 4/1/04

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1 COUNTY OF ORANGE,
2 Plaintiff/Petitioner,
3 v.
4 STATE OF CALIFORNIA; STEVE WESTLY in his official capacity as California
5 State Controller; PHIL ANGELIDES in his official capacity as California State Treasurer;
6 DONNA ARDUIN in her official capacity as Director of the California State Department of
7 Finance; and DOES 1 through 50, inclusive,
8 Defendants/Respondents.
9

10 A. **The parties to the above case, by their attorneys:** plaintiffs/petitioners, County
11 of San Diego, County Counsel John J. Sansone, by Timothy M. Barry, Senior Deputy; County
12 of Orange, County Counsel Benjamin P. de Mayo, by Wendy J. Phillips, Deputy; and
13 defendants/respondents by Deputy Attorneys Generals Michelle Mitchell Lopez and Leslie
14 Lopez conferred and discussed settlement but could not settle the case. They are prepared for
15 trial.
16 B. **Nature of Case:**
17 Plaintiffs/Petitioners, County of San Diego and County of Orange ("the Counties"), seek
18 reimbursement of costs incurred in relation to providing various State mandated programs at the
19 local level. The California Constitution requires the State to reimburse counties for costs
20 incurred in relation to providing mandated programs. Between the two counties, reimbursement
21 for 50 different mandated programs are at issue, totaling more than $110 million. The Counties
22 seek a writ of mandate compelling Defendants/Respondents: State of California, Phil Angelides
23 (Treasurer), Steve Westly (Controller) and Tom Campbell (Director of Finance), (collectively
24 "the State"), to pay the Counties as required by the California Constitution. The Counties are
25 requesting the court to order the State to pay the mandated costs from funds within the State's
26 budget that are appropriated but unencumbered.
27 C. **Legal issues which *are not* in dispute:**
28 1. In November of 2004, the Court granted the Counties' joint motion for judgment

1 on the pleadings. In that Order, the Court granted Counties declaratory relief stating that the
2 State "failed to reimburse costs incurred in providing state mandated services and programs for
3 fiscal years 2002-2004 in violation of the State's constitutional and statutory obligations."

4 2. The State does not dispute that the Counties are owed reimbursement for costs
5 incurred in relation to providing state mandated services.

6 **3. The State agrees that the amounts set forth on Exhibits "A" and "B"**
7 **accurately reflect the amount of the Counties claims, that the State has not disputed the**
8 **amount of the claims as reflected on Exhibits "A" except for Item 22, FY 03-04, Item 28,**
9 **FY 99-00, and Item 46, FY 94-95 and 95-96 and on Exhibit "B" except for Items _____,**
10 **and that the State has not paid the Counties' claims.**

11 **D. Legal issues which *are* in dispute:**

12 1. The State disputes that this court may issue a writ of mandate requiring the State
13 reimburse the Counties. The State asserts that, as a result of section 6 being amended in
14 November 2004 and because of Government Code section 17617, it has no "clear, present, and
15 ministerial duty" to reimburse the Counties. The State asserts that article XIII B, section 6(b)(2)
16 of the California Constitution and Government Code section 17617 control the State's duty to
17 reimburse the specific mandated costs at issue in this case and thus, the State has 15 years,
18 commencing in fiscal year 2006-07, to reimburse the Counties.

19 2. The State also disputes that there are "appropriated but unencumbered funds" from
20 which the Court may order the State to pay the obligation owing the Counties. At issue for the
21 trial is whether there are funds in the State's Fiscal Year 2005-06 Budget that have been
22 appropriated by the Legislature for specific departments and programs from which the Court
23 may legally order, in conformity with applicable case law, the State to pay the Counties to
24 satisfy the reimbursement obligation.

25 **E. Exhibits:** See Attachments "E-1" and "E-2"
26 **F. Plaintiff's standard jury instructions:** Not Applicable
27 **G. Defendant's standard jury instructions:** Not Applicable
28 **H. Special verdict form:** Not Applicable

ATTACHMENT D

found the passage of Proposition 1A in November of 2004 did not render the writ moot. By stipulation, amended complaints were filed alleging defendants' failure to fully pay the mandates from 1994 through 2004. Beginning in the 2002-2003 budget year, some mandates were suspended while the Legislature funded the remaining mandates in the amount of $1,000. See Government Code section 17581.

The State's motion for Summary Adjudication was denied. The Court of Appeal denied the application for a Writ of Mandate, and court trial commenced on November 28, 2005.

III. Facts

A. Plaintiffs' Case

Plaintiffs and the State agreed before trial the State owed all the money sought by plaintiff except for about $22,000. Plaintiffs proved they were owed the additional sum of about $22,000 that relates to Mandate 22. (SIDS-Contact by Local Officers) During closing argument, defendant agreed it owed plaintiffs all the money sought by plaintiffs in accord with California Constitution, Article XIIIB, section 6. Thus, San Diego County is owed $41,652,974 and Orange County is owed $72,755,977. Plaintiffs are seeking a total judgment of $114,408,951.

In order to have a court order the immediate embargo of State budget funds owed to pay a State debt, California Courts have required the funds in the state budget be generally related to the funds missing. See *Butt v. State of California* (1992) 4 Cal.4th 668, 699-700. To make this connection, plaintiffs called Mr. William Hamm, the former Legislative Analyst for the State of California. In response to questions regarding different mandates he used terms such as reasonably related, generally related, similar purpose, and similar. For purposes of simplicity, the court has given him the benefit of the doubt and construed his testimony as being the funds sought to reimburse the counties, were

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State Controller's Office
Division of Audits
Post Office Box 942850
Sacramento, California 94250-5874

http://www.sco.ca.gov

S05-MCC-016

Exhibit C

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561

SERVICES TO HANDICAPPED STUDENTS

For State Controller Use Only

Program **111**

(19) Program Number 00111
(20) Date File ___/___/___
(21) LRS Input ___/___/___

(01)
(02) 9930
Cour AUDITOR-CONTROLLER
COUNTY OF ORANGE
Stree P.O. BOX 567
City SANTA ANA, CA 92702

Reimbursement Claim Data	
(22) HDS-1, (03)(a)	
(23) HDS-1, (03)(b)	
(24) HDS-1, (03)(c)	
(25) HDS-1, (04)(1)(d)	
(26) HDS-1, (04)(2)(d)	
(27) HDS-1, (04)(3)(d)	
(28) HDS-1, (04)(4)(d)	
(29) HDS-1, (04)(5)(d)	
(30) HDS-1, (06)	
(31) HDS-3, (05)	329,822
(32) HDS-3, (06)	
(33) HDS-3, (07)	
(34)	
(35)	
(36)	

Type of Claim	Estimated Claim		Reimbursement Claim	
	(03) Estimated	X	(09) Reimbursement	
	(04) Combined		(10) Combined	
	(05) Amended		(11) Amended	X
Fiscal Year of Cost	(06)	2001/2002	(12)	2000/2001
Total Claimed Amount	(07)	13,000,000	(13)	12,831,341
Less: 10% Late Penalty, not to exceed $1,000			(14)	
Less: Prior Claim Payment Received			(15)	9,511,041
Net Claimed Amount			(16)	3,320,300
Due from State	(08)	13,000,000	(17)	3,320,300
Due to State			(18)	0

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985, .

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985, set forth on the attached statements.

Signature of Authorized Officer: Claire Moynihan
Date: 11-21-02

Claire Moynihan
Type or Print Name

Manager, Financial Reporting & Mandated Costs
Title

(39) Name of Contact Person for Claim

JoAnn Hover

Telephone Number (714) 834-5252 Ext.
E-mail Address joann.hover@ac.ocgov.com

Form FAM-27 (Revised 9/01)
Chapter 1747/84 and 1274/85

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY	FORM HDS-3

(01) Claimant County of Orange/Health Care Agency	(02) Type of Claims Reimbursement [X] Estimated [ ]	Fiscal Year 2000/2001

(03)	**Reimbursable Components**	
	Assessment of Individuals With Exceptional Needs	
	(a) Assessment: Interviews, Review of Records, Observations, Testing, etc. From A-5	5,426,476
	(b) Residential Placement: IEP Reviews, Case Management, and Expanded IEP	
	(c) Related Services: Attendance at IEP meetings, Meeting with IEP Members and Parents, and Review of Independent Assessment.	
	(d) Due Process Proceedings	
	(e) Administrative Costs From A-11	2,516,904
	Mental Health Treatment	
	(f) Treatment Services: Short-Doyle Program From A-10	9,223,879
	(g) Administrative Costs From A-12	3,409,319
(04)	Sub-total for Assessment of Individual with Exceptional Needs [Sum of (03), lines (a) to (e)]	7,943,380
(05)	Less: Amount Received from Short-Doyle / Medi-Cal (FFP only) From G-4	329,822
(06)	Less: Amount Received from State Categorical Funding	
(07)	Less: Amount Received from Other (Patient Fees)	
(08)	Total for Assessment of Individual with Exceptional Needs [Line (04) minus the sum of lines (05) to (07)	7,613,558
(09)	Sub-Total for Mental Health Treatment [block (03), lines (f) and (g)]	12,633,198
(10)	Less: Non-Categorical State General / Realignment Funds Per T. Horton See A-1.1	5,998,426
(11)	Less: Amount Received from State Categorical Funds From F-1	699,001
(12)	Less: Amount Received from Short-Doyle / Medi-Cal (FFP only) From G-4	625,439
(13)	Less: Amount Received from Other (SAMSHA Grant, Patient Fees) From J-3	92,549
(14)	Total Mental health Treatment [Line (09) minus the sum of lines (10) to (13)]	5,217,783
(15)	Total Claimed Amount [Sum of line (08) and line (14)] To A-1	12,831,341

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant: **County of Orange Health Care Agency**

(02) Fiscal Year Costs Were Incurred: **FY 2000-01**

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

- [X] Assessment
- [ ] Treatment Services
- [ ] Residential Placement
- [ ] Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
East County - Santa Ana	3006	15/01	From: B-3 285,807 ✓	0.9100	From B-3 260,084 ✓
East County - Santa Ana	3006	15/30	377,118	1.1700	441,228
West County - Westminster	3009	15/01	B-3 256,575 ✓	1.3000	B-3 333,548 ✓
West County - Westminster	3009	15/30	221,958	1.6700	370,670
CGC Inc. - Fullerton	3051	15/01	67,606	0.7100	48,000
CGC Inc. - Fullerton	3051	15/30	184,167	1.3700	252,309
South County - Laguna	8002	15/01	B-3 779,805 ✓	0.5700	B-3 444,489 ✓
South County - Laguna	8002	15/30	771,741	0.7400	571,088
CGC Inc. - Santa Ana	8034	15/01	41,815	0.8300	34,706
CGC Inc. - Santa Ana	8034	15/30	115,437	1.6100	185,854
Western Youth - Garden Grove	8035	15/01	101,204	1.2200	123,469
Western Youth - Garden Grove	8035	15/30	116,379	1.2200	141,982
O.C. -Orange - City Dr.	8042	15/01	3,700	0.8000	2,960
O.C. -Orange - City Dr.	8042	15/30	425	1.0200	434
Western Youth - Laguna	8056	15/01	289,658	1.2200	353,383
Western Youth - Laguna	8056	15/30	502,500	1.2200	613,050
Western Youth - Anaheim	8090	15/01	85,984	1.2200	104,900
Western Youth - Anaheim	8090	15/30	99,568	1.2200	121,473
North County - Placentia	8067	15/01	B-3 316,678 ✓	0.8700	B-3 275,510 ✓
North County - Placentia	8067	15/30	317,772	1.1200	355,905
Page Total			4,935,897		5,035,042

(05) Total Subtotal Page: 1 of 3

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 2000-01

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

[X] Assessment
[ ] Treatment Services
[ ] Residential Placement
[ ] Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
OLIVE CREST - ANAHEIM	8078	15/01	2,920	1.5500	4,526
OLIVE CREST - ANAHEIM	8078	15/30	1,377	1.6100	2,217
ASPEN HEALTH SERVICES - CM	30BC	15/01	41,109	1.2900	53,031
ASPEN HEALTH SERVICES - CM	30BC	15/30	45,179	1.6600	74,997
					-
ASPEN HEALTH SERVICES - GG	30BE	15/01	13,871	1.2900	17,894
ASPEN HEALTH SERVICES - GG	30BE	15/30	12,765	1.6600	21,190
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/01	2,845	1.2900	3,670
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/30	-	1.6600	0
LATINO PSYCH CENTER	30AE	15/01	12,753	1.6000	20,405
LATINO PSYCH CENTER	30AE	15/30	22,326	2.0600	45,992
WESTERN YOUTH - LAGUNA HILLS	30CH	15/01	6,796	1.2200	8,291
WESTERN YOUTH - LAGUNA HILLS	30CH	15/30	13,631	1.2200	16,630
WESTERN YOUTH - HUNTINGTON BEACH	30AG	15/01	7,405	1.2200	9,034
WESTERN YOUTH - HUNTINGTON BEACH	30AG	15/30	3,389	1.2200	4,135
CGC, INC - BUENA PARK	30CE	15/01	9,404	0.6400	6,019
CGC, INC - BUENA PARK	30CE	15/30	48,326	1.2300	59,441
PACIFIC CLINICS	30AZ	15/01	1,019	1.2100	1,233
PACIFIC CLINICS	30AZ	15/30	347	1.5600	541
SCCS - COSTA MESA	30CD	15/01	8,824	2.7800	24,531
SCCS - COSTA MESA	30CD	15/30	2,822	3.5700	10,075
Page Total			257,108		383,852

(05) Total Subtotal Page: 2 of 3

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 2000-01

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

[X] Assessment
[ ] Treatment Services
[ ] Residential Placement
[ ] Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
OLIVE CREST - SANTA ANA	30AU	15/01	99	1.5500	153
OLIVE CREST - SANTA ANA	30AU	15/30	-	1.6100	0
LATINO PSYCH CENTER - ANAHEIM	30BB	15/01	3,078	1.6000	4,925
LATINO PSYCH CENTER - ANAHEIM	30BB	15/30	1,215	2.0600	2,503
PAGE TOTAL			4,392		7,581
Grand Total			5,197,397		

(05) Total X Subtotal Page: 3 of 3 — 5,426,475

Revised to deduct SED Case Mgmt units to be claimed on SB90-SED Claim

do 9/20/04

A-5

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 2000-01

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

☐ Assessment
☒ Treatment Services
☐ Residential Placement
☐ Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
East County - Santa Ana	3006	15/10	100,282	1.1700	117,330
East County - Santa Ana	3006	15/40	445,891	1.1700	521,692
East County - Santa Ana	3006	15/50	-	1.1700	0
East County - Santa Ana	3006	15/60	69,980	2.1900	153,256
East County - Santa Ana	3006	15/70	6,937	1.7600	12,209
West County - Westminster	3009	15/10	143,512	1.6700	239,665
West County - Westminster	3009	15/40	483,627	1.6700	807,657
West County - Westminster	3009	15/50	47,622	1.6700	79,529
West County - Westminster	3009	15/60	89,278	3.1200	278,547
West County - Westminster	3009	15/70	8,056	2.5100	20,221
CGC Inc. - Fullerton	3051	15/10	82,243	1.3700	112,673
CGC Inc. - Fullerton	3051	15/40	142,527	1.3700	195,262
CGC Inc. - Fullerton	3051	15/50	76,825	1.3700	105,250
CGC Inc. - Fullerton	3051	15/58	20,570	1.3600	27,975
CGC Inc. - Fullerton	3051	15/60	10,310	2.2900	23,610
CGC Inc. - Fullerton	3051	15/70	2,795	2.5500	7,127
Sounty County - Laguna	8002	15/10	516,012	0.7400	381,849
Sounty County - Laguna	8002	15/40	1,502,785	0.7400	1,112,061
Sounty County - Laguna	8002	15/50	114,591	0.7400	84,797
Sounty County - Laguna	8002	15/58	258	0.7400	191
Sounty County - Laguna	8002	15/60	195,843	1.3700	268,305
Sounty County - Laguna	8002	15/70	15,066	1.1100	16,723
CGC Inc. - Santa Ana	8034	15/10	115,150	1.6100	185,392
CGC Inc. - Santa Ana	8034	15/40	307,642	1.6100	495,304
CGC Inc. - Santa Ana	8034	15/50	852	1.6100	1,372
CGC Inc. - Santa Ana	8034	15/58	360	1.3600	490
CGC Inc. - Santa Ana	8034	15/60	15,369	2.7000	41,496
CGC Inc. - Santa Ana	8034	15/70	3,250	3.0000	9,750
Page Total			4,517,633		5,299,733

(05) Total Subtotal Page: 1 of 5

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS COMPONENT / ACTIVITY COST DETAIL	Form HDS-4

(01) Claimant County of Orange Health Care Agency	(02) Fiscal Year Costs Were Incurred FY 2000-01

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

- [ ] Assessment
- [X] Treatment Services
- [ ] Residential Placement
- [ ] Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
Western Youth - Garden Grove	8035	15/10	102,481	1.2200	125,027
Western Youth - Garden Grove	8035	15/40	324,715	1.2200	396,152
Western Youth - Garden Grove	8035	15/50	11,345	1.2200	13,841
Western Youth - Garden Grove	8035	15/58	3,332	1.2200	4,065
Western Youth - Garden Grove	8035	15/60	22,580	1.2200	27,548
Western Youth - Garden Grove	8035	15/70	4,533	1.2200	5,530
O.C. -Orange - City Dr.	8042	15/10	-	1.0200	0
O.C. -Orange - City Dr.	8042	15/40	5,810	1.0200	5,926
O.C. -Orange - City Dr.	8042	15/50	-	1.0200	0
O.C. -Orange - City Dr.	8042	15/60	3,262	1.9100	6,230
O.C. -Orange - City Dr.	8042	15/70	400	1.5300	612
Western Youth - Laguna	8056	15/10	187,587	1.2200	228,856
Western Youth - Laguna	8056	15/40	730,689	1.2200	891,441
Western Youth - Laguna	8056	15/50	40,773	1.2200	49,743
Western Youth - Laguna	8056	15/60	64,182	1.2200	78,302
Western Youth - Laguna	8056	15/70	3,028	1.2200	3,694
Western Youth - Anaheim	8090	15/10	38,585	1.2200	47,074
Western Youth - Anaheim	8090	15/40	170,040	1.2200	207,449
Western Youth - Anaheim	8090	15/50	3,020	1.2200	3,684
Western Youth - Anaheim	8090	15/60	19,686	1.2200	24,017
Western Youth - Anaheim	8090	15/70	217	1.2200	265
North County - Placentia	8067	15/10	182,348	1.1200	204,230
North County - Placentia	8067	15/40	558,663	1.1200	625,703
North County - Placentia	8067	15/50	1,920	1.1200	2,150
North County - Placentia	8067	15/60	176,000	2.0800	366,080
North County - Placentia	8067	15/70	7,652	1.6700	12,779
Page Total			2,662,848		3,330,398

(05) Total Subtotal Page: 2 of 5

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS COMPONENT / ACTIVITY COST DETAIL	Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 2000-01

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

- [ ] Assessment
- [X] Treatment Services
- [ ] Residential Placement
- [ ] Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
OLIVE CREST - ANAHEIM	8078	15/10	407	1.9400	790
OLIVE CREST - ANAHEIM	8078	15/40	3,482	1.5700	5,467
OLIVE CREST - ANAHEIM	8078	15/50	-	1.5500	0
OLIVE CREST - ANAHEIM	8078	15/60	5,708	1.5400	8,790
OLIVE CREST - ANAHEIM	8078	15/70	1,474	1.3700	2,019
ASPEN HEALTH SERVICES - CM	30BC	15/10	4,905	1.6600	8,142
ASPEN HEALTH SERVICES - CM	30BC	15/40	69,295	1.6600	115,030
ASPEN HEALTH SERVICES - CM	30BC	15/50	-	1.6600	0
ASPEN HEALTH SERVICES - CM	30BC	15/60	3,011	3.0800	9,274
ASPEN HEALTH SERVICES - CM	30BC	15/70	885	2.4800	2,195
ASPEN HEALTH SERVICES - GG	30BE	15/10	3,781	1.6600	6,276
ASPEN HEALTH SERVICES - GG	30BE	15/40	17,050	1.6600	28,303
ASPEN HEALTH SERVICES - GG	30BE	15/50	-	1.6600	0
ASPEN HEALTH SERVICES - GG	30BE	15/60	1,422	3.0800	4,380
ASPEN HEALTH SERVICES - GG	30BE	15/70	287	2.4800	712
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/10	955	1.6600	1,585
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/40	4,891	1.6600	8,119
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/50	-	1.6600	-
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/60	214	3.0800	659
ASPEN HEALTH SERVICES - TUSTIN	30BF	15/70	-	2.4800	0
LATINO PSYCH CENTER	30AE	15/10	7,466	2.0300	15,156
LATINO PSYCH CENTER	30AE	15/40	32,848	2.0600	67,667
LATINO PSYCH CENTER	30AE	15/50	395	2.0600	814
LATINO PSYCH CENTER	30AE	15/60	2,225	3.8400	8,544
LATINO PSYCH CENTER	30AE	15/70	60	3.0900	185
Page Total			160,761		294,107

(05) Total Subtotal Page: 3 of 5

Chapters 1747/84 and 1274/85 **New 3/97**

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS COMPONENT / ACTIVITY COST DETAIL	Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 2000-01

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

- [ ] Assessment
- [X] Treatment Services
- [ ] Residential Placement
- [ ] Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
WYS - LAGUNA HILLS	30CH	15/10	5,164	1.2200	6,300
WYS - LAGUNA HILLS	30CH	15/40	20,500	1.2200	25,010
WYS - LAGUNA HILLS	30CH	15/50	538	1.2200	656
WYS - LAGUNA HILLS	30CH	15/60	1,130	1.2200	1,379
WYS - LAGUNA HILLS	30CH	15/70	-	1.2200	0
WYS - HUNTINGTON BEACH	30AG	15/10	4,001	1.2200	4,881
WYS - HUNTINGTON BEACH	30AG	15/40	19,420	1.2200	23,692
WYS - HUNTINGTON BEACH	30AG	15/50	825	1.2200	1,007
WYS - HUNTINGTON BEACH	30AG	15/60	1,940	1.2200	2,367
WYS - HUNTINGTON BEACH	30AG	15/70	625	1.2200	763
CGC - BUENA PARK	30CE	15/10	7,863	1.2300	9,671
CGC - BUENA PARK	30CE	15/40	16,900	1.2300	20,787
CGC - BUENA PARK	30CE	15/50	740	1.2300	910
CGC - BUENA PARK	30CE	15/58	-	1.3600	0
CGC - BUENA PARK	30CE	15/60	830	2.0700	1,718
CGC - BUENA PARK	30CE	15/70	65	2.2900	149
PACIFIC CLINICS	30AZ	15/10	-	1.5600	0
PACIFIC CLINICS	30AZ	15/40	664	1.5600	1,036
PACIFIC CLINICS	30AZ	15/50	-	1.5600	-
PACIFIC CLINICS	30AZ	15/58	-	1.5600	0
PACIFIC CLINICS	30AZ	15/60	238	2.9000	690
PACIFIC CLINICS	30AZ	15/70	-	2.3300	0
Page Total			81,443		101,016

(05) Total Subtotal Page: 4 of 5

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS COMPONENT / ACTIVITY COST DETAIL	Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 2000-01

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

- [ ] Assessment
- [X] Treatment Services
- [ ] Residential Placement
- [ ] Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
SCCS	30CD	15/10	2,672	3.5700	9,539
SCCS	30CD	15/40	25,880	3.5700	92,392
SCCS	30CD	15/50	22,860	3.5700	81,610
SCCS	30CD	15/58	-	3.5700	0
SCCS	30CD	15/60	-	-	0
SCCS	30CD	15/70	-	3.5700	0
OLIVE CREST - SANTA ANA	30AU	15/10	-	1.9400	0
OLIVE CREST - SANTA ANA	30AU	15/40	126	1.5700	198
OLIVE CREST - SANTA ANA	30AU	15/50	78	1.5500	121
OLIVE CREST - SANTA ANA	30AU	15/58	-	0.5700	0
OLIVE CREST - SANTA ANA	30AU	15/60	40	1.5400	62
OLIVE CREST - SANTA ANA	30AU	15/70	-	1.3700	0
LATINO PSYCH CENTER	30BB	15/10	1,367	2.0600	2,816
LATINO PSYCH CENTER	30BB	15/40	4,624	2.0600	9,525
LATINO PSYCH CENTER	30BB	15/50	-	2.0600	0
LATINO PSYCH CENTER	30BB	15/60	615	3.8400	2,362
LATINO PSYCH CENTER	30BB	15/70	-	3.0900	0
Page Total			58,262		198,625
Grand Total			7,480,947		

(05) Total X Subtotal Page: 5 of 5 *no change* 9,223,879

DD 9/20/04

Chapters 1747/84 and 1274/85 New 3/97

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-6

(01) Claimant: **County of Orange Health Care Agency**

(02) Fiscal Year Costs Were Incurred: FY 2000 /2001

(03) Reimbursable Components: Administrative Costs

[X] Assessment of Individuals [ ] Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).

(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
			Object Accounts			
Administrative Cost (See Attached Schedule)			2,516,904			
Totals			2,516,904	0	0	0

(05) Total Direct Costs	2,516,904
Indirect Costs	
(06) Indirect Cost Rate [From ICRP]	0.00%
(07) Total Indirect Costs [Line (06) x line (04)(d)] or [Line (06) x { (04)(d) + (04)(e) }]	
(08) Total Direct and Indirect Costs [Line (05) + line (07)]	2,516,904

no change
do 9/20/04

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-6

(01) Claimant	(02) Fiscal Year Costs Were Incurred
County of Orange Health Care Agency	**FY 2000 /2001**

(03) Reimbursable Components: Administrative Costs

[ ] Assessment of Individuals [X] Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).

(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
			Object Accounts			
Administrative Cost (See Attached Schedule)			3,409,319			
Totals			3,409,319	0	0	0

(05) Total Direct Costs	3,409,319
Indirect Costs	
(06) Indirect Cost Rate [From ICRP]	0.00%
(07) Total Indirect Costs [Line (06) x line (04)(d)] or [Line (06) x { (04)(d) + (04)(e) }]	
(08) Total Direct and Indirect Costs [Line (05) + line (07)]	3,409,319

no change
DS 9/20/04

12. CLAIM CERTIFICATION

Read, sign, and date this section and insert at the end of the incorrect reduction claim submission. *

This claim alleges an incorrect reduction of a reimbursement claim filed with the State Controller's Office pursuant to Government Code section 17561. This incorrect reduction claim is filed pursuant to Government Code section 17551, subdivision (d). I hereby declare, under penalty of perjury under the laws of the State of California, that the information in this incorrect reduction claim submission is true and complete to the best of my own knowledge or information or belief.

Mark A. Refowitz
Print or Type Name of Authorized Local Agency or School District Official

Behavioral Health Director
Print or Type Title

[signature]
Signature of Authorized Local Agency or School District Official

March 4, 2010
Date

* *If the declarant for this Claim Certification is different from the Claimant contact identified in section 2 of the incorrect reduction claim form, please provide the declarant's address, telephone number, fax number, and e-mail address below.*

Exhibit B

JOHN CHIANG
California State Controller

RECEIVED
OCT 07 2009
COMMISSION ON STATE MANDATES

October 6, 2009

Nancy Patton, Asst. Executive Director
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814

Bang Quan
Auditor-Controller, Orange County
P.O. Box 567
Santa Ana, CA 92702

Re: **Incorrect Reduction Claim**
Handicapped and Disabled Students, 05-4282-I-02
County of Orange, Claimant
Statutes 1984, Chapter 1747; Statutes 1985, Chapter 1274
Fiscal Years 1997-98 and 1998-99

Dear Ms. Patton and Ms. Quan:

This letter is in response to the above-entitled Incorrect Reduction Claim. The subject claims were reduced because the Claimant included costs for services that were not reimbursable under the Parameters & Guidelines in effect during the audited years. In addition, the Incorrect Reduction Claim should be denied because it was filed after the expiration of the deadline provided for in regulation. The reductions were appropriate and in accordance with law.

The Controller's Office is empowered to audit claims for mandated costs and to reduce those that are "excessive or unreasonable."[1] This power has been affirmed in recent cases, such as the Incorrect Reductions Claims (IRCs) for the *Graduation Requirements* mandate.[2] If the claimant disputes the adjustments made by the Controller pursuant to that power, the burden is upon it to demonstrate that it is entitled to the full amount of the claim. This principle likewise has been upheld in the *Graduation Requirements* line of IRCs.[3] See also Evidence Code section 500.[4] In this case, the audit determined that the Claimant was claiming costs for medication monitoring, which was not an identified reimbursable activity in the Parameters & Guidelines as amended in 1996, and effective for the two fiscal years that were the subject of this audit. Therefore, these claimed costs are unsupportable and thus, disallowed.

[1] See Government Code section 17561, subdivisions (d)(1)(C) and (d)(2), and section 17564.
[2] See for example, the Statement of Decision in the Incorrect Reduction Claim of San Diego Unified School District [No. CSM 4435-I-01 and 4435-I-37], adopted September 28, 2000, at page 9.
[3] See for example, the Statement of Decision in the Incorrect Reduction Claim of San Diego Unified School District [No. CSM 4435-I-01 and 4435-I-37], adopted September 28, 2000, at page 16.
[4] "Except as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting."

300 Capitol Mall, Suite 1850, Sacramento, CA 95814 ♦ P.O. Box 942850, Sacramento, CA 94250
Phone: (916) 445-2636 ♦ Fax: (916) 322-1220

The Claimant points to subsequent amendments of the Parameters & Guidelines adopted in 2005 and 2006, which refer to medication monitoring, to support its claim that it is a reimbursable cost. However, amendments to Parameters & Guidelines are not retroactive, and the amendments in question were only effective from July 1, 2001, forward, therefore, they did not apply to the fiscal years audited. In fact, the addition of medication monitoring as a reimbursable activity supports the Controller's position in this case; it does not contradict it, as the Claimant asserts. If medication monitoring had been covered in the prior Parameters & Guidelines, there would have been no need to add an explicit reference to the activity in the amendments. Therefore, medication monitoring was not a reimbursable activity prior to July 1, 2001.

In addition, the Claimant failed to file its Incorrect Reduction Claim in the time frame required by Title 2 of the California Code of Regulations, Section 1185. Section 1185, subdivision (b) states that "[a]ll incorrect reduction claims shall be filed with the commission no later than three (3) years following the date of the Office of State Controller's remittance advice or other notice of adjustment notifying the claimant of a reduction." In this case, the remittance advice and accompanying letter were dated April 28, 2003 (See pages 2-5 of Exhibit C of the Claimant's IRC). Therefore, the last date to file an IRC was April 28, 2003. However, the Claimant did not file its claim until May 1, 2003, outside the time frame provided, and thus, the IRC is precluded by the limitations provision of Section 1185.

Enclosed please find a complete detailed analysis from our Division of Audits, exhibits, and supporting documentation with declaration.

Sincerely,

Shawn D. Silva

SHAWN D. SILVA
Senior Staff Counsel

SDS/ac

Enclosure

cc: Denise Steckler, Manager, Financial Reporting & Mandated Costs, Orange County
Ginny Brummels, Division of Accounting & Reporting, State Controller's Office (w/o encl.)
Jim Spano, Division of Audits, State Controller's Office (w/o encl.)

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PROOF OF SERVICE

I am employed in the County of Sacramento, State of California. At the time of service, I was at least 18 years of age, a United States citizen employed in the county where the mailing occurred, and not a party to the within action. My business address is 300 Capitol Mall, Suite 1850, Sacramento, CA 95814.

On October 6, 2009, I served the foregoing document entitled:

SCO'S RESPONSE TO THE INCORRECT REDUCTION CLAIM FOR COUNTY OF ORANGE, CSM 05-4282-I-02

on all interested parties in this action by placing a true and correct copy thereof enclosed in a sealed envelope, addressed as follows:

Nancy Patton *(original)*
Assistant Executive Director
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814

Bang Quan
Auditor-Controller, Orange County
P.O. Box 567
Santa Ana, CA 92702

Denise Steckler, Manager
Financial Reporting & Mandated Costs
Orange County
515 Sycamore Street, 5th Floor
Santa Ana, CA 92702

[X] **BY MAIL**
I placed the envelope for collection and processing for mailing following this business's ordinary practice with which I am readily familiar. On the same day correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service.

[ ] **BY PERSONAL SERVICE**
I caused to be delivered by hand to the above-listed addressees.

[ ] **BY OVERNIGHT MAIL/COURIER**
To expedite the delivery of the above-named document, said document was sent via overnight courier for next day delivery to the above-listed party.

[ ] **BY FACSIMILE TRANSMISSION**
In addition to the manner of service indicated above, a copy was sent by facsimile transmission to the above-listed party.

I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made. I declare under penalty of perjury under the laws of California that the foregoing is true and correct.

Executed on October 6, 2009, at Sacramento, California.

Amber A. Camarena

RESPONSE BY THE STATE CONTROLLER'S OFFICE TO THE INCORRECT REDUCTION CLAIM BY ORANGE COUNTY
Handicapped and Disabled Students Program

Table of Contents

Description | **Page**

State Controller's Office's Response to County's Comments

Declaration .... Tab 1

State Controller's Office (SCO) Analysis and Response .... Tab 2

Parameters and Guidelines (August 29, 1996) .... Tab 3

Parameters and Guidelines for the Handicapped and Disabled Students II Program
(adopted December 9, 2005; corrected on July 21, 2006) .... Tab 4

California Code of Regulations, Title 2, Division 2, Section 1185 .... Tab 5

Attachment – County's Comments

Incorrect Reduction Claim (May 1, 2006)

SCO Claiming Instructions (March 1997) .... Exhibit A

SCO Audit Report (December 26, 2002) .... Exhibit B

County Letter (dated May 22, 2003) .... Exhibit C

County Reimbursement Claim—FY 1997-98 .... Exhibit D

County Reimbursement Claim—FY 1998-99 .... Exhibit E

Parameters and Guidelines for the Handicapped and Disabled Students II Program
(adopted December 9, 2005) .... Exhibit F

TAB 1

OFFICE OF THE STATE CONTROLLER
300 Capitol Mall, Suite 1850
Sacramento, CA 94250
Telephone No.: (916) 445-6854

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

INCORRECT REDUCTION CLAIM ON: *Handicapped and Disabled Students Program* Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 ORANGE COUNTY, Claimant	No.: CSM 05-4282-I-02 AFFIDAVIT OF BUREAU CHIEF

I, Jim L. Spano, make the following declarations:

1) I am an employee of the State Controller's Office (SCO) and am over the age of 18 years.

2) I am currently employed as a bureau chief, and have been so since April 21, 2000.

3) I am a California Certified Public Accountant.

4) I reviewed the work performed by the SCO auditor.

5) Any attached copies of records are true copies of records, as provided by Orange County or retained at our place of business.

6) The records include claims for reimbursement, with attached supporting documentation, explanatory letters, or other documents relating to the above-entitled Incorrect Reduction Claim.

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7) A field audit of the claims for fiscal year (FY) 1997-98 and FY 1998-99 commenced on May 25, 2000, and ended on June 19, 2002.

I do declare that the above declarations are made under penalty of perjury and are true and correct to the best of my knowledge, and that such knowledge is based on personal observation, information, or belief.

Date: October 9, 2007

OFFICE OF THE STATE CONTROLLER

By: ______________________________
Jim L. Spano, Chief
Mandated Cost Audits Bureau
Division of Audits
State Controller's Office

TAB 2

STATE CONTROLLER'S OFFICE ANALYSIS AND RESPONSE TO THE INCORRECT REDUCTION CLAIM BY ORANGE COUNTY
For Fiscal Year (FY) 1997-98 and FY 1998-99

Handicapped and Disabled Students Program
Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985

SUMMARY

The following is the State Controller's Office's (SCO) response to the Incorrect Reduction Claim (IRC) that Orange County filed with the Commission on State Mandates (CSM) on May 1, 2006. The SCO audited the district's claims for costs of the legislatively mandated Handicapped and Disabled Students Program for the period of July 1, 1997, through June 30, 1999. The SCO issued its final report on December 26, 2002 **(Exhibit B)**.

The county submitted reimbursement claims totaling $22,506,432 for FY 1997-98 and FY 1998-99 as follows:

- FY 1997-98—$10,585,561 **(Exhibit D)**
- FY 1998-99—$11,920,871 **(Exhibit E)**

The SCO determined that $20,715,374 is allowable and $1,791,058 is unallowable. The unallowable costs occurred because the district claimed ineligible costs, which caused an overstatement in the county's Medi-Cal revenue offsets. The State paid the district $22,506,432. The amount paid that exceeded allowable costs claimed by $1,791,058. The following table summarizes the audit results.

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustments
July 1, 1997, through June 30, 1998			
Assessment/case management costs	$ 4,043,451	$ 3,989,022	$ (54,429)
Administrative costs	1,112,862	1,112,862	—
Offsetting revenues:			
State categorical funds	—	(270,394)	(270,394)
Short-Doyle/Medi-Cal funds	(263,748)	(263,748)	—
Net assessment/case management costs	4,892,565	4,567,742	(324,823)
Treatment costs	6,763,081	5,847,999	(915,082)
Administrative costs	1,410,275	1,410,275	—
Offsetting revenues:			
State categorical funds	(791,550)	(521,156)	270,394
Short-Doyle/Medi-Cal funds	(768,403)	(671,642)	96,761
Net treatment costs	6,613,403	6,065,476	(547,927)
Realignment funding adjustment	(920,407)	(844,150)	76,257
Net treatment costs after funding adjustment	5,692,996	5,221,326	(471,670)
Total program costs	$ 10,585,561	9,789,068	$ (796,493)
Amount paid by the State		(10,585,561)[1]	
Allowable costs claimed in excess of (less than) amount paid		$ (796,493)	

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustments
July 1, 1998, through June 30, 1999			
Assessment/case management costs	$ 3,682,941	$ 3,620,072	$ (62,869)
Administrative costs	1,315,956	1,315,956	—
Offsetting revenues:			
State categorical funds	—	(255,773)	(255,773)
Short-Doyle/Medi-Cal funds	(317,663)	(317,663)	—
Net assessment/case management costs	4,681,234	4,362,592	(318,642)
Treatment costs	6,778,968	5,755,530	(1,023,438)
Administrative costs	1,883,623	1,883,623	—
Offsetting revenues:			
State categorical funds	(791,550)	(535,777)	255,773
Short-Doyle/Medi-Cal funds	(631,404)	(539,662)	91,742
Net treatment costs	7,239,637	6,563,714	(675,923)
Total program costs	$ 11,920,871	10,926,306	$ (994,565)
Amount paid by the State		(11,920,871)[1]	
Allowable costs claimed in excess of (less than) amount paid		$ (994,565)	
Summary: July 1, 1997, through June 30, 1999			
Assessment/case management costs	$ 7,726,392	$ 7,609,094	$ (117,298)
Administrative costs	2,428,818	2,428,818	—
Offsetting revenues:			
State categorical funds	—	(526,167)	(526,167)
Short-Doyle/Medi-Cal funds	(581,411)	(581,411)	—
Net assessment/case management costs	9,573,799	8,930,334	(643,465)
Treatment costs	13,542,049	11,603,529	(1,938,520)
Administrative costs	3,293,898	3,293,898	—
Offsetting revenues:			
State categorical funds	(1,583,100)	(1,056,933)	526,167
Short-Doyle/Medi-Cal funds	(1,399,807)	(1,211,304)	188,503
Net treatment costs	13,853,040	12,629,190	(1,223,850)
Realignment funding adjustment	(920,407)	(844,150)	76,257
Net treatment costs after funding adjustment	12,932,633	11,785,050	(1,147,593)
Total program costs	$ 22,506,432	20,715,374	$ (1,791,058)
Amount paid by the State		(22,506,432)[1]	
Allowable costs claimed in excess of (less than) amount paid		$ (1,791,058)	

[1] Payment information is based on amount paid when the final report was issued.

The district's Incorrect Reduction Claim contests audit adjustments relating to Medication Monitoring treatment costs, totaling $1,629,815. The county believes that this activity was reimbursable during the audit period.

I. SCO REBUTTAL TO STATEMENT OF DISPUTE— CLARIFICATION OF REIMBURSABLE ACTIVITIES, CLAIM CRITERIA, AND DOCUMENTATION REQUIREMENTS

Parameters and Guidelines

On April 26, 1990, the Commission on State Mandates (CSM) determined that Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985 imposed a state mandate reimbursable under *Government Code* Section 17561. The CSM adopted the program's parameters and guidelines on August 22, 1991, and amended it on August 29, 1996 (**Tab 3**). On May 26, 2005, the CSM adopted a Statement of Decision on reconsideration of the program pursuant to Senate Bill 1895 (Statutes of 2004, Chapter 493). The CSM determined that the 1990 statement of decision does not fully identify all of the activities mandated by the statutes and regulations. Subsequently, the CSM amended the parameters and guidelines on January 26, 2006, and again on January 25, 2007.

Following are excerpts from the parameters and guidelines, amended on August 29, 1996, that are applicable for the audit period of FY 1996-97, FY 1997-98, and FY 1998-99.

Section 1, Summary of the Mandate, states:

> Chapter 1747 of the Statutes of 1984 added Chapter 26, commencing with section 7570, to Division 7 of Title 1 of the Government Code (Gov. Code).
>
> Chapter 1274 of the Statutes of 1985 amended sections 7572, 7572.5, 7575, 7576, 7579, 7582, and 7587 of, amended and repealed 7583 of, added section 7586.5 and 7586.7 to, and repealed 7574 of, the Gov. Code, and amended section 5651 of the Welfare and Institutions Code.
>
> To the extent that Gov. Code section 7572 and section 60040, Title 2, Code of California Regulations, require county participation in the mental health assessment for "individuals with exceptional needs, " such legislation and regulations impose a new program or higher level of service upon a county. Furthermore, any related county participation on the expanded "Individualized Education Program" (IEP) team and case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed, " pursuant to subdivisions (a), (b), and (c) of Gov. Code section 7572.5 and their implementing regulations, impose a new program or higher level of service upon a county.
>
> The aforementioned mandatory county participation in the IEP process is not subject to the Short-Doyle Act, and accordingly, such costs related thereto are costs mandated by the state and are fully reimbursable within the meaning of section 6, article XIIIB of the California Constitution.
>
> The provisions of Welfare and Institutions Code section 5651, subdivision (g), result in a higher level of service within the county Short-Doyle program because the mental health services, pursuant to Gov. Code sections 7571 and 7576 and their implementing regulations,

must be included in the county Short-Doyle annual plan. Such services include psychotherapy and other mental health services provided to "individuals with exceptional needs, " including those designated as "seriously emotionally disturbed, "and required in such individual's IEP.

Such mental health services are subject to the current cost sharing formula of the Short-Doyle Act, through which the state provides ninety (90) percent of the total costs of the Short-Doyle program, and the county is required to provide the remaining ten (10) percent of the funds. Accordingly, only ten (10) percent of such program costs are reimbursable within the meaning of section 6, article XIIIB of the California Constitution as costs mandated by the state, because the Short-Doyle Act currently provides counties ninety (90) percent of the costs of furnishing those mental health services set forth in Gov. Code section 757 1 and 7576 and their implementing regulations, and described in the county's Short-Doyle annual plan pursuant to Welfare and Institutions Code section 5651, subdivision (g).

Section III identifies eligible claimants as follows.

All counties.

Section V identifies reimbursable activities as follows.

A. One Hundred (100) percent of any costs related to IEP Participation, Assessment, and Case Management:

1. The scope of the mandate is one hundred (100) percent reimbursement, except that for individuals billed to Medi-Cal only, the Federal Financing Participation portion (FFP) for these activities should be deducted from reimbursable activities not subject to the Short-Doyle Act.

2. For each eligible claimant, the following cost items are one hundred (100) percent reimbursable (Gov. Code section 7572, subd. (d)(1)):

a. Whenever an LEA refers an individual suspected of being an 'individual with exceptional needs' to the local mental health department, mental health assessment and recommendation by qualified mental health professionals in conformance with assessment procedures set forth in Article 2 (commencing with section 56320) of Chapter 4 of part 30 of Division 4 of the Education Code, and regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, including but not limited to the following mandated services:

i. interview with the child and family,
ii. collateral interviews, as necessary,
iii. review of the records,
iv. observation of the child at school, and
v. psychological testing and/or psychiatric assessment, as necessary.

b. Review and discussion of mental health assessment and recommendation with parent and appropriate IEP team members. (Government Code section 7572, subd. (d)(1)).

c. Attendance by the mental health professional who conducted the assessment at IEP meetings, when requested. (Government Code section 7572, subd. (d)(l)) *

d. Review by claimant's mental health professional of any independent assessment(s) submitted by the IEP team. (Government Code section 7572, subd. (d)(2)).

e. When the written mental health assessment report provided by the local mental health program determines that an "individual with special needs' is 'seriously emotionally disturbed', and any member of the IEP team recommends residential placement based upon relevant assessment information, inclusion of the claimant's mental health professional on that individual's expanded IEP team.

f. When the IEP prescribes residential placement for an 'individual with exceptional needs ' who is 'seriously emotionally disturbed, ' claimant's mental health personnel's identification of out-of-home placement, case management, six month review of IEP, and expanded IEP responsibilities. (Government Code section 7572.5).

g. Required participation in due process procedures, including but not limited to due process hearings.

3. One hundred (100) percent of any administrative costs related to IEP Participation, Assessment, and Case Management, whether direct or indirect.

B. Ten (10) percent of any costs related to mental health treatment services rendered under the Short-Doyle Act:

1. The scope of the mandate is ten (10) percent reimbursement.

2. For each eligible claimant, the following cost items, for the provision of mental health services when required by a child's individualized education program, are ten (10) percent reimbursable (Government Code 7576):

a. Individual therapy,

b. Collateral therapy and contacts,

c. Group therapy,

d. Day treatment, and

e. Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.

3. Ten (10) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

Section VI describes the claim preparation process as follows.

There are two satisfactory methods of submitting claims for reimbursement of increased costs incurred to comply with the mandate:

A. Actual Increased Costs Method. To claim under the Actual Increased Costs Method, report actual increased costs incurred for each of the following expense categories in the format specified by the State Controller's claiming instructions. Attach supporting schedules as necessary:

   1 Employee Salaries and Benefits: Show the classification of the employees involved, mandated functions performed, number of hours devoted to the function, and hourly rates and benefits.

   2 Services and supplies: Include only expenditures which can be identified as a direct cost resulting from the mandate. List cost of materials acquired which have been consumed or expended specifically for the purpose of this mandate.

   3 Direct Administrative Costs:

      a. One hundred (100) percent of any direct administrative costs related to IEP Participation, Assessment, and Case Management.

      b. Ten (10) percent of any direct administrative costs related to mental health treatment rendered under the Short-Doyle Act.

   4 Indirect Administrative and Overhead Costs: To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions:

      a. Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SC0 for program indirect costs which exceeds ten (10) percent of total program direct labor costs, excluding fringe benefits.

OR if an indirect cost rate greater than ten (10) percent is being claimed,

      b. By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program; each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SC0 sources must not exceed the total for those items as computed in the ICRP(s).

B. Cost Report Method. Under this claiming method the mandate reimbursement claim is still submitted on the State Controller's claiming forms in accordance with the claiming instructions. A complete copy of the annual cost report including all supporting schedules attached to the cost report as filed with DMH must also be filed with the claim forms submitted to the State Controller.

1 To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions :

a. Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs which exceeds ten (10) percent of total program direct labor costs, excluding fringe benefits.

OR if an indirect cost rate greater than ten (10) percent is being claimed,

b. By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program; each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP(s).

Section VII describes the supporting data that must be maintained as follows.

For auditing purposes, all costs claimed must be traceable to source documents and/or worksheets that show evidence of the validity of such costs. Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district is subject to audit by the State Controller no later than two years after the end of the calendar year in which the reimbursement claim is filed or last amended. However, if no funds are appropriated for the program for the fiscal year for which the claim is made, the time for the State Controller to initiate an audit shall commence to run from the date of initial payment of the claim.

SCO Claiming Instructions

In compliance with Government Code section 17558, the SCO issues claiming instructions for mandated programs, to assist local agencies and school districts in claiming reimbursable costs. The SCO issued revised claiming instructions for Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985 in March 1997 **(Exhibit B)**. The county used this version to file its FY 1997-98 and FY 1998-99 reimbursement claims **(Exhibits D** and **E)**.

II. THE COUNTY CLAIMED INELIGBLE COSTS UNDER THE MANDATE PROGRAM

Issue

For the audit period of July 1, 1997, through June 30, 1999, the county claimed various ineligible case management and treatment costs, totaling $2,055,818. Of that amount, $1,629,815 relates to Medication Monitoring treatment costs. The county believes that Medication Monitoring treatment costs are reimbursable during the audit period.

SCO Analysis:

The county claimed case management costs for clients placed in out-of-state residential facilities that are not reimbursable under the Handicapped and Disabled Students (HDS) program, but rather under the Seriously Emotionally Disturbed Pupils: Out-of-State Mental Health Services (SED) program. In a response to the audit report, the county concurred with the SCO and subsequently filed claims under the SED program.

The county also claimed treatment costs for medication support and crisis intervention. These costs are not reimbursable under the HDS program.

The parameters and guidelines allow reimbursement of increased costs incurred for the mandated program. The parameters and guidelines in effect during the audit period specify that the following treatment services are reimbursable:

- Individual therapy,
- Collateral therapy and contacts,
- Group therapy,
- Day treatment, and
- Mental health portion of residential treatment in excess of the California Department of Social Services' payments for residential placement.

County's Response

On May 2, 2003, the County of Orange received remittance advices totaling $1,791,058 resulting from findings from the State Controller's Office (SCO) audit of the County's SB90 *Handicapped and Disabled Students* (HDS) claims for Fiscal Years (FY) 1997/98 and 1998/99. Of this amount, $1,629,815 pertained to medication monitoring services that were at that time disallowed.

In our appeal to the findings of this audit, we cited several sections from the California Code of Regulations, Welfare and Institutions Code, and the Government Code that all mandate medication monitoring as a necessary part of treatment services provided for under Chapter 26.5 of the Government Code, and therefore were implied as claimable under the Parameters and Guidelines for this mandate at that time. The SCO's denial of this appeal was based on

the argument that the Parameters and Guidelines specify all activities covered by the mandate, and by not specifically including medication monitoring, this implied that these services were not covered.

However, as a result of a successful HDS test claim by another entity, the Commission on State Mandates issued new parameters and guidelines for this claim on February 17, 2006 that allowed for the reimbursement of medication monitoring service. Based on this action, which validates that medication monitoring is and always has been a mandated activity, the County is thereby submitting this Incorrect Reduction Claim for the previously disallowed medication monitoring expenditures from FY 1997/98 and 1998/99 in the amount of $1,629,815 per Title 2, Division 2, Chapter 2.5, Article 1 of the California Code of Regulations.

SCO's Comment

The county does not dispute the costs of out-of-state residential facilities and crisis intervention that are not reimbursable under this mandate.

The county does dispute the unallowable medication monitoring costs. The SCO concurs that medication monitoring were defined in regulation at the time the parameters and guidelines on the Handicapped and Disabled Students (HDS) program were adopted. However, this activity was not included in the adoption of the parameters and guidelines as a reimbursable cost.

In 2001, the Counties of Los Angeles and Stanislaus filed a test claim to amend the parameters and guidelines on the original test claim decision on the Handicapped and Disabled Students (HDS) program. According to the test claim, the counties were seeking reimbursement for the activities required by statutory and regulatory amendments to the original HDS program. The amendments included treatment services such as psychotherapy, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management. Upon reconsideration of the parameters and guidelines, the CSM addressed the amendments and adopted a statement of decision in HDS II on May 26, 2005. The amended parameters and guidelines were adopted December 9, 2005, and corrected on July 21, 2006 **(Tab 4)**. They defined the period of reimbursement for the amended portions, beginning July 1, 2001. Consequently, medication monitoring costs claimed prior to July 1, 2001, are not reimbursable.

III. STATUTE OF LIMITATIONS

Issue

The statute of limitations for the county's IRC has expired.

SCO Analysis:

This issue is not an audit finding. The SCO reviewed the filing dates of the county's IRC for FY 1997-98 and FY 1998-99 and found the claim to be invalid, due to the expiration of the statute of limitations. Title 2, California Code of Regulations, Div 2, section 1185 (b) states

that all incorrect reduction claims shall be filed with the commission no later than three (3) years following the date of the State Controller's Office remittance advice or other notice of adjustment notifying the claimant of a reduction (**Tab 5**). The SCO issued a remittance advice to the county on April 28, 2003. Therefore, the deadline for the county to file an IRC was on April 28, 2006. However, the county filed its IRC with the CSM on May 1, 2006. Therefore, the IRC is invalid.

IV. CONCLUSION

The SCO audited the claims filed by Orange County for costs of the legislatively mandated Handicapped and Disabled Students Program (Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985) for the period of July 1, 1997, through June 30, 1999. The county claimed ineligible costs, which caused an overstatement in the county's Medi-Cal revenue offsets.

Additionally, the county filed an invalid IRC, due to the expiration of the statute of limitations.

In conclusion, the CSM should find that (1) the SCO correctly reduced the county's FY 1997-98 claim by $759,114 (2) the SCO correctly reduced the county's FY 1998-99 claim by $870,701; and (3) the county did not file an IRC within the statute of limitations.

V. CERTIFICATION

I hereby certify by my signature below that the statements made in this document are true and correct of my own knowledge, or, as to all other matters, I believe them to be true and correct based upon information and belief.

Executed on October 9, 2007, at Sacramento, California, by:

Jim L. Spano, Chief
Mandated Cost Audits Bureau
Division of Audits
State Controller's Office

TAB 3

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BEFORE THE
COMMISSION ON STATE MANDATES
STATE OF CALIFORNIA

Claim Of: County of San Bernardino Claimant	No. CSM-4282 Title 2, Cal. Code Regs., Div. 9, Sections 60000-60200 Chapter 1747, Statutes of 1984 Chapter 1274, Statutes of 1985 *Handicapped and Disabled Students*

PARAMETERS AND GUIDELINES

The attached *amended* Parameters and Guidelines of the Commission on State Mandates are hereby adopted by the Commission on State Mandates in the above entitled matter.

IT IS SO ORDERED August 29, 1996.

K.G. Stewart

Kirk G. Stewart, Executive Director
Commission on State Mandates

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FILE COPY

Hearing Date: August 29, 1996
File Number: CSM-4282
Commission Staff: Lucila Ledesma
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Original Adopted: 8/22/9 1
Revised: **8/29/96**

PARAMETERS AND GUIDELINES

Sections 60000-60200
Title 2, California Code of Regulations, Division 9
Chapter 1747, Statutes of 1984
Chapter 1274, Statutes of 1985
Handicapped and Disabled Students

I. SUMMARY OF MANDATE

Chapter 1747 of the Statutes of 1984 added Chapter 26, commencing with section 7570, to Division 7 of Title 1 of the Government code (Gov. Code).

Chapter 1274 of the Statutes of 1985 amended sections 7572, 7572.5, 7575, 7576, 7579, 7582, and 7587 of, amended and repealed 7583 of, added section 7586.5 and 7586.7 to, and repealed 7574 of, the Gov. Code, and amended section 5651 of the Welfare and Institutions Code.

To the extent that Gov. Code section 7572 and section 60040, Title 2, Code of California Regulations, require county participation in the mental health assessment for "'individuals with exceptional needs, " such legislation and regulations impose a new program or higher level of service upon a county. Furthermore, any related county participation on the expanded "Individualized Education Program" (IEP) team and case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed, " pursuant to subdivisions (a), (b), and (c) of Gov. Code section 7572.5 and their implementing regulations, impose a new program or higher level of service upon a county.

The aforementioned mandatory county participation in the IEP process is not subject to the Short-Doyle Act, and accordingly, such costs related thereto are costs mandated by the state and are fully reimbursable within the meaning of section 6, article XIIIB of the California Constitution.

The provisions of Welfare and Institutions Code section 565 1, subdivision (g), result in a higher level of service within the county Short-Doyle program because the mental health services, pursuant to Gov. Code sections 757 1 and 7576 and their implementing regulations, must be included in the county Short-Doyle annual plan. Such services include psychotherapy and other mental health services provided to "individuals with exceptional needs, " including those designated as "seriously emotionally disturbed, " and required in such individual's IEP.

Such mental health services are subject to the current cost sharing formula of the Short-Doyle Act, through which the state provides ninety (90) percent of the total costs of the Short-Doyle program, and the county is required to provide the remaining ten (10) percent of the funds. Accordingly, only ten (10) percent of such program costs are reimbursable within the meaning of section 6, article XIIIB of the California Constitution as costs mandated by the state, because the Short-Doyle Act currently provides counties ninety (90) percent of the costs of furnishing those mental health services set forth in Gov. Code section 757 1 and 7576 and their implementing regulations, and described in the county's Short-Doyle annual plan pursuant to Welfare and Institutions Code section 565 1, subdivision (g).

II. COMMISSION ON STATE MANDATES' DECISION

The Commission on State Mandates, at its April 26, 1990 hearing, adopted a Statement of Decision that determined that County participation in the IEP process is a state mandated program and any costs related thereto are fully reimbursable. Furthermore, any mental health treatment required by an IEP is subject to the Short-Doyle cost sharing formula. Consequently, only the county's Short-Doyle share (i.e., ten percent) of the mental health treatment costs will be reimbursed as costs mandated by the state.

III. ELIGIBLE CLAIMANTS

All counties

IV. PERIOD OF REIMBURSEMENT

Section 17557 of the Gov. Code states that a test claim must be submitted on or before December 3 1 following a given fiscal year to establish eligibility for that year. The test claim for this mandate was filed on August 17, 1987, all costs incurred on or after July 1, 1986, are reimbursable.

Actual costs for one fiscal year should be included in each claim, and estimated costs for the subsequent year may be included on the same claim, if applicable, pursuant to Government Code section 17561.

If the total costs for a given fiscal year do not exceed $200, no reimbursement shall be allowed, except as otherwise allowed by Gov. Code section 17564.

V. REIMBURSABLE COSTS

A. One Hundred (100) percent of any costs related to IEP Participation, Assessment, and Case Management:

1. The scope of the mandate is one hundred (100) percent reimbursement, except that for individuals billed to Medi-Cal only, the Federal Financing Participation portion (FFP) for these activities should be deducted from reimbursable activities not subject to the Short-Doyle Act.

2. For each eligible claimant, the following cost items are one hundred (100) percent reimbursable (Gov. Code, section 7572, subd. (d)(1)):

   a. Whenever an LEA refers an individual suspected of being an 'individual with exceptional needs' to the local mental health department, mental health assessment and recommendation by qualified mental health professionals in conformance with assessment procedures set forth in Article 2 (commencing with section 56320) of Chapter 4 of part 30 of Division 4 of the Education Code, and regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, including but not limited to the following mandated services:
   i. interview with the child and family,
   ii. collateral interviews, as necessary,
   iii. review of the records,
   iv. observation of the child at school, and
   v. psychological testing and/or psychiatric assessment, as necessary.

   b. Review and discussion of mental health assessment and recommendation with parent and appropriate IEP team members. (Government Code section 7572, subd. (d)(1)).

   c. Attendance by the mental health professional who conducted the assessment at IEP meetings, when requested. (Government Code section 7572, subd. (d)(1)).

   d. Review by claimant's mental health professional of any independent assessment(s) submitted by the IEP team. (Government Code section 7572, subd. (d)(2)).

   e. When the written mental health assessment report provided by the local mental health program determines that an "individual with special needs' is 'seriously emotionally disturbed', and any member of the IEP team recommends residential placement based upon relevant assessment information, inclusion of

the claimant's mental health professional on that individual's expanded IEP team.

f. When the IEP prescribes residential placement for an 'individual with exceptional needs ' who is 'seriously emotionally disturbed, ' claimant' s mental health personnel's identification of out-of-home placement, case management, six month review of IEP, and expanded IEP responsibilities. (Government Code section 7572.5).

g. Required participation in due process procedures, including but not limited to due process hearings.

3. One hundred (100) percent of any administrative costs related to IEP Participation, Assessment, and Case Management, whether direct or indirect.

B. Ten (10) percent of any costs related to mental health treatment services rendered under the Short-Doyle Act :

1. The scope of the mandate is ten (10) percent reimbursement.

2. For each eligible claimant, the following cost items, for the provision of mental health services when required by a child's individualized education program, are ten (10) percent reimbursable (Government Code 7576):

a. Individual therapy,

b. Collateral therapy and contacts,

c. Group therapy,

d. Day treatment, and

e. Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.

3. Ten (10) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

VI. CLAIM PREPARATION

There are two satisfactory methods of submitting claims for reimbursement of increased costs incurred to comply with the mandate:

A. Actual Increased Costs Method. To claim under the Actual Increased Costs Method, report actual increased costs incurred for each of the following expense categories in the format specified by the State Controller's claiming instructions. Attach supporting schedules as necessary:

1. Employee Salaries and Benefits: Show the classification of the employees involved, mandated functions performed, number of hours devoted to the function, and hourly rates and benefits.

2. Services and supplies: Include only expenditures which can be identified as a direct cost resulting from the mandate. List cost of materials acquired which have been consumed or expended specifically for the purpose of this mandate.

3. Direct Administrative Costs:

   a. One hundred (100) percent of any direct administrative costs related to IEP Participation, Assessment, and Case Management.

   b. Ten (10) percent of any direct administrative costs related to mental health treatment rendered under the Short-Doyle Act.

4. Indirect Administrative and Overhead Costs: To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions:

   a. Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs which exceeds ten (10) percent of total program direct labor costs, excluding fringe benefits.

   OR if an indirect cost rate greater than ten (10) percent is being claimed,

   b. By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program; each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP(s).

B. Cost Report Method. Under this claiming method the mandate reimbursement claim is still submitted on the State Controller's claiming forms in accordance with the claiming instructions. A complete copy of the annual cost report including all supporting schedules attached to the cost report as filed with DMH must also be filed with the claim forms submitted to the State Controller.

1. To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions :

   a. Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs which exceeds ten (10) percent of total program direct labor costs, excluding fringe benefits.

   OR if an indirect cost rate greater than ten (10) percent is being claimed,

   b. By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program; each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP(s).

VII. SUPPORTING DATA

For auditing purposes, all costs claimed must be traceable to source documents and/or worksheets that show evidence of the validity of such costs. Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district is subject to audit by the State Controller no later than two years after the end of the calendar year in which the reimbursement claim is filed or last amended. However, if no funds are appropriated for the program for the fiscal year for which the claim is made, the time for the State Controller to initiate an audit shall commence to run from the date of initial payment of the claim.

VIII. OFFSETTING SAVINGS AND OTHER REIMBURSEMENTS

A. Any offsetting savings the claimant experiences as a direct result of this statute must be deducted from the costs claimed.

B. The following reimbursements for this mandate shall be deducted from the claim:

1. Any direct payments (categorical funding) received from the State which are specifically allocated to this program; and

2. Any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g. federal, state, etc.

IX. REQUIRED CERTIFICATION

An authorized representative of the claimant will be required to provide a certification of claim, as specified in the State Controller's claiming instructions, for those costs mandated by the state contained herein.

TAB 4

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE PARAMETERS AND GUIDELINES ON: Government Code Sections 7572.55 and 7576 Statutes 1994, Chapter 1128, Statutes 1996, Chapter 654, and California Code of Regulations, Title 2, Sections 60000 et seq. (Emergency Regulations Effective July 1, 1998 [Register 99, No. 33]) Filed on June 20, 2005, by County of Los Angeles, Claimant.	No. 02-TC-40, 02-TC-49 *Handicapped and Disabled Students II* ADOPTION OF PARAMETERS AND GUIDELINES PURSUANT TO GOVERNMENT CODE SECTION 17557 AND TITLE 2, CALIFORNIA CODE OF REGULATIONS, SECTION 1183.14 *(Adopted on December 9, 2005; Corrected on July 21, 2006)*

CORRECTED PARAMETERS AND GUIDELINES

On December 9, 2005, the Commission on State Mandates adopted the parameters and guidelines for this program and authorized staff to make technical corrections to the parameters and guidelines following the hearing.

On May 26, 2006, the State Controller's Office filed a letter with the Commission requesting a technical correction to the parameters and guidelines to identify and add to the parameters and guidelines language allowing eligible claimants to claim costs using the cost report method. The cost report method was included in the parameters and guidelines for the original *Handicapped and Disabled Students* program (CSM 4282) and inadvertently omitted from the parameters and guidelines for *Handicapped and Disabled Student II*. The State Controller's Office states the following:

> The majority of claimants use this method to claim costs for the mental health portion of their claims. The resulting costs represent actual costs consistent with the cost accounting methodology used to report overall mental health costs to the State Department of Mental Health. The method is also consistent with how counties contract with mental health service vendors to provide services.

The following language is added to Section V, Claim Preparation and Submission:

Cost Report Method

A. Cost Report Method

Under this claiming method, the mandate reimbursement claim is still submitted on the State Controller's claiming forms in accordance with claiming instructions. A complete copy of the annual cost report, including all supporting schedules attached to the cost report as filed

with the Department of Mental Health, must also be filed with the claim forms submitted to the State Controller.

B. Indirect Cost Rates

To the extent that reimbursable indirect costs have not already been reimbursed by the Department of Mental Health from categorical funding sources, they may be claimed under this method.

Indirect costs are costs that are incurred for a common or joint purpose, benefiting more than one program, and are not directly assignable to a particular department or program without efforts disproportionate to the result achieved. Indirect costs may include (1) the overhead costs of the unit performing the mandate; and (2) the costs of the central government services distributed to the other departments based on a systematic and rational basis through a cost allocation plan.

Compensation for indirect costs is eligible for reimbursement utilizing the procedure provided in the Office of Management and Budget (OMB) Circular A-87. Claimants have the option of using 10% of labor, excluding fringe benefits, or preparing an Indirect Cost Rate Proposal (ICRP) if the indirect cost rate claimed exceeds 10%.

If the claimant chooses to prepare an ICRP, both the direct costs (as defined and described in OMB Circular A-87 Attachments A and B) and the indirect costs shall exclude capital expenditures and unallowable costs (as defined and described in OMB A-87 Attachments A and B). However, unallowable costs must be included in the direct costs if they represent activities to which indirect costs are properly allocable.

The distribution base may be (1) total direct costs (excluding capital expenditures and other distorting items, such as pass-through funds, major subcontracts, etc.), (2) direct salaries and wages, or (3) another base which results in an equitable distribution.

In calculating an ICRP, the claimant shall have the choice of one of the following methodologies:

1. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) classifying a department's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate which is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected; or

2. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) separating a department into groups, such as divisions or sections, and then classifying the division's or section's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate that is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected.

In addition, a correction is made to Section IV(G), Reimbursable Activities, "Providing Psychotherapy or Other Mental Health Treatment Services." On May 26, 2005, the Commission adopted the Statement of Decision in the reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10), and approved as a reimbursable state-mandated activity, beginning July 1, 2004, providing mental health assessments, collateral services, intensive day treatment, and day rehabilitation services when required by the pupil's IEP. When adopting the parameters and guidelines on the reconsidered program, the Commission determined that it would include psychotherapy and other mental health treatment activities in the parameters and guidelines in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), since it had an earlier reimbursement period (July 1, 2001) and the definition of mental health treatment services was substantially amended. The Commission's finding is as follows:

> The Commission's Statement of Decision authorizes reimbursement for providing psychotherapy or other mental health services identified in a pupil's IEP, as defined in sections 542 and 543 of the Department of Mental Health regulations. As noted in the Statement of Decision, however, the original definition of the types of services was repealed and replaced by the Departments of Mental Health and Education in 1998. [Footnote omitted.] The Commission concluded that the new definition of psychological and other mental health services constitutes a reimbursable new program or higher level of service in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) and, in December 2005, the Commission adopted parameters and guidelines for *Handicapped and Disabled Students II.* The reimbursement period for *Handicapped and Disabled Students II* begins July 1, 2001.
>
> Therefore, costs incurred by eligible claimants for the activity of providing psychological and other mental health services may be claimed pursuant to the parameters and guidelines in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), beginning July 1, 2001. Since the proposed parameters and guidelines for the reconsideration of the original *Handicapped and Disabled Students* program (04-RL-4282-10) has a later reimbursement period, the activity is not included in these proposed parameters and guidelines.[1]

On May 26, 2005, the Commission adopted the Statement of Decision in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) and found that section 60020 of the test claim regulations continued to include mental health assessments, collateral services, intensive day treatment, and day rehabilitation in the definition of "mental health services." However, the activities of crisis intervention, vocational services, and socialization services were deleted by the test claim regulations. The Commission also found that case management services were reimbursable. The Commission's findings are as follows:

> In addition, section 60020, subdivision (i), changed the definition of mental health services. As indicated above, the former regulations defined "psychotherapy and other mental health services" to include the day services and outpatient services identified in sections 542 and 543 of the Department of Mental Health regulations. (Former Cal. Code Regs., tit. 2, § 60020, subd. (a).) Under the prior regulations, these services included the following: day care

[1] Staff analysis adopted by Commission on January 26, 2006.

intensive services, day care habilitative (counseling and rehabilitative) services, vocational services, socialization services, collateral services, assessment, individual therapy, group therapy, medication (including the prescribing, administration, or dispensing of medications, and the evaluation of side effects and results of the medication), and crisis intervention.

Section 60020, subdivision (i), of the regulations, now defines "mental health services" as follows:

> "Mental health services" means mental health assessment and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code: psychotherapy as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management. These services shall be provided directly or by contract at the discretion of the community mental health service of the county of origin.

Section 60020 of the test claim regulations continues to include mental health assessments, collateral services, intensive day treatment, and day rehabilitation within the definition of "mental health services." These services are not new. [Footnote deleted.]

However, the activities of crisis intervention, vocational services, and socialization services were deleted by the test claim regulations. ...

Thus, counties are not eligible for reimbursement for providing crisis intervention, vocational services, and socialization services since these activities were repealed as of July 1, 1998.

Nevertheless, section 60020 of the regulations increases the level of service of counties providing mental health services by including case management services and "psychotherapy" within the meaning of "mental health services." The regulation defines psychotherapy to include both individual and group therapy, based on the definition in Business and Professions Code section 2903.

The parameters and guidelines for the program, however, inadvertently included in the identification of activities that were *not* reimbursable the activities of mental health assessments, collateral services, intensive day treatment, and case management. The parameters and guidelines also inadvertently did not include reimbursement for day rehabilitation services. Based on the Commission's Statements of Decision for these programs, claimants are eligible for reimbursement, beginning July 1, 2001, for case management services. Claimants are also eligible for reimbursement, beginning July 1, 2004, for mental health assessments, collateral services, intensive day treatment, and day rehabilitation services.

Thus, in order for the parameters and guidelines to conform to the findings of the Commission in the reconsideration of *Handicapped and Disabled Students* (04-RL-4292-10) and *Handicapped and Disabled Students II* (02-TC-40, 02-TC-49), Section IV(G) is corrected as follows:

G. Provide Psychotherapy or Other Mental Health Treatment Services (Cal. Code Regs., tit. 2, §§ 60020, subd. (i), 60050, subd. (b), 60200, subd. (c))

1) The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)
2) The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)
3) Provide case management services to a pupil when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
4) Provide case management services and individual or group psychotherapy services, as defined in Business and Professions Code section 2903, when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
5) *Beginning July 1, 2004*, provide mental health assessments, collateral services, intensive day treatment, and day rehabilitation services when required by the pupil's IEP. These services shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
6) Provide medication monitoring services when required by the pupil's IEP. "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subds. (f) and (i).)
7) Notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of a service, or when the pupil is no longer participating in treatment. ((Cal. Code Regs., tit. 2, § 60050, subd. (b).)

(When providing psychotherapy or other mental health treatment services, the activities of ~~mental health assessments, collateral services, intensive day treatment, case management,~~ crisis intervention, vocational services, and socialization services are not reimbursable.)

Finally, language is added to Section III, Period of Reimbursement, to reflect the July 1, 2004 period of reimbursement for the activities of mental health assessments, collateral services, intensive day treatment, and day rehabilitation services.

Dated: ______________________

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Paula Higashi, Executive Director

CORRECTED
PARAMETERS AND GUIDELINES

Government Code Sections 7572.55 and 7576
Statutes 1994, Chapter 1128, Statutes 1996, Chapter 654

California Code of Regulations, Title 2, Sections 60000 et seq.
(emergency regulations effective July 1, 1998 [Register 98, No. 26],
final regulations effective August 9, 1999 [Register 99, No. 33])

Handicapped and Disabled Students II (02-TC-40/02-TC-49)

Counties of Stanislaus and Los Angeles, Claimants

I. SUMMARY OF THE MANDATE

On May 26, 2005, the Commission on State Mandates (Commission) adopted its Statement of Decision in *Handicapped and Disabled Students II*, finding that Government Code sections 7572.55 and 7576, as added or amended in 1994 and 1996, and the joint regulations adopted by the Departments of Mental Health and Education as emergency regulations in 1998 and final regulations in 1999 (Cal. Code Regs., tit. 2, §§ 60000 et seq.), impose a reimbursable state-mandated program on counties within the meaning of article XIII B, section 6 of the California Constitution and Government Code section 17514.

The Handicapped and Disabled Students program was initially enacted in 1984 and 1985 as the state's response to federal legislation (Individuals with Disabilities Education Act, or IDEA) that guaranteed to disabled pupils, including those with mental health needs, the right to receive a free and appropriate public education. Three other Statements of Decision have been adopted by the Commission on the Handicapped and Disabled Students program. They include *Handicapped and Disabled Students* (CSM 4282), *Reconsideration of Handicapped and Disabled Students* (04-RL-4282-10), and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05).

Eligible claimants are ***not*** entitled to reimbursement under these parameters and guidelines for the activities approved by the Commission in *Handicapped and Disabled Students* (CSM 4282), *Reconsideration of Handicapped and Disabled Students* (04-RL-4282-10), and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05).

These parameters and guidelines address only the amendments to the *Handicapped and Disabled Students* program. The Commission found, pursuant to the court's ruling in *Hayes v. Commission on State Mandates* (1992) 11 Cal. App.4th 1564, that Government Code sections 7572.55 and 7576, as added or amended in 1994 and 1996, and the joint regulations adopted by the Departments of Mental Health and Education as emergency regulations in 1998 and final regulations in 1999, constitute a reimbursable state-mandated program since the state "freely chose" to impose the costs upon counties as a means of implementing the federal IDEA program.

II. ELIGIBLE CLAIMANTS

Any county, or city and county, that incurs increased costs as a result of this reimbursable state-mandated program is eligible to claim reimbursement of those costs.

III. PERIOD OF REIMBURSEMENT

Government Code section 17557 states that a test claim shall be submitted on or before June 30 following a given fiscal year to establish eligibility for reimbursement for that fiscal year. The test claim for this mandate was filed by the County of Stanislaus (02-TC-40) on June 27, 2003, and filed by the County of Los Angeles (02-TC-49) on June 30, 2003. Therefore, except as expressly provided in Section IV. G (5), the period of reimbursement begins July 1, 2001.

Actual costs for one fiscal year shall be included in each claim. Estimated costs for the subsequent year may be included on the same claim, if applicable. Pursuant to Government Code section 17561, subdivision (d)(l)(A), all claims for reimbursement of initial fiscal year costs shall be submitted to the State Controller within 120 days of the issuance date for the claiming instructions.

If the total costs for a given year do not exceed $1,000, no reimbursement shall be allowed, except as otherwise allowed by Government Code section 17564.

IV. REIMBURSABLE ACTIVITIES

To be eligible for mandated cost reimbursement for any given fiscal year, only actual costs may be claimed. Actual costs are those costs actually incurred to implement the mandated activities. Actual costs must be traceable and supported by source documents that show the validity of such costs, when they were incurred, and their relationship to the reimbursable activities. A source document is a document created at or near the same time the actual cost was incurred for the event or activity in question. Source documents may include, but are not limited to, employee time records or time logs, sign-in sheets, invoices, and receipts.

Evidence corroborating the source documents may include, but is not limited to, worksheets, cost allocation reports (system generated), purchase orders, contracts, agendas, calendars, and declarations. Declarations must include a certification or declaration stating, "I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct," and must further comply with the requirements of Code of Civil Procedure section 2015.5. Evidence corroborating the source documents may include data relevant to the reimbursable activities otherwise reported in compliance with local, state, and federal government requirements. However, corroborating documents cannot be substituted for source documents.

The claimant is only allowed to claim and be reimbursed for increased costs for reimbursable activities identified below. Claims should *exclude* reimbursable costs included in claims previously filed, beginning in fiscal year 2001-2002, for the Handicapped and Disabled Students program (CSM 4282).[2] Increased cost is limited to the cost of an activity that the claimant is required to incur as a result of the mandate.

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[2] Some costs disallowed by the State Controller's Office in prior years are now reimbursable beginning July 1, 2001 (e.g., medication monitoring). Rather than claimants re-filing claims for

For each eligible claimant, the following activities are eligible for reimbursement:

A. Interagency Agreements (Cal. Code Regs., tit. 2, § 60030)

The one-time activity of revising the interagency agreement with each local educational agency to include the following eight procedures:

1) Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code section 7575, subdivision (f). For purposes of this subdivision only, the term "appropriate" means any service identified in the pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(2).)

2) A host county to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)

3) Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)

4) At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)

5) The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)

6) The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)

7) The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)

8) Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)

(The activities of updating or renewing the interagency agreements are not reimbursable.)

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those costs incurred beginning July 1, 2001, the State Controller's Office will reissue the audit reports.

B. Referral and Mental Health Assessments (Gov. Code, § 7576; Cal. Code Regs., tit. 2, §§ 60040, 60045)

1) Work collaboratively with the local educational agency to ensure that assessments performed prior to referral are as useful as possible to the community mental health service in determining the need for mental health services and the level of services needed. (Gov. Code, § 7576, subd. (b)(1).)

2) A county that receives a referral for a pupil with a different county of origin shall forward the referral within one working day to the county of origin. (Gov. Code, § 7576, subd. (g); Cal. Code Regs., tit. 2, § 60040, subd. (g).)

3) If the county determines that a mental health assessment is not necessary, the county shall document the reasons and notify the parents and the local educational agency of the county determination within one day. (Cal Code Regs., tit. 2, § 60045, subd. (a)(1).)

4) If the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral. (Cal. Code Regs., tit. 2, § 60045, subd. (a)(2).)

5) Notify the local educational agency when an assessment is determined necessary. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)

6) Provide the assessment plan to the parent. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)

7) Report back to the referring local educational agency or IEP team within 30 days from the date of the receipt of the referral if no parental consent for a mental health assessment has been obtained. (Cal. Code Regs., tit. 2, § 60045, subd. (c).)

8) Notify the local educational agency within one working day after receipt of the parent's written consent for the mental health assessment to establish the date of the IEP meeting. (Cal. Code Regs., tit. 2, § 60045, subd. (d).)

9) Provide the parent with written notification that the parent may require the assessor to attend the IEP meeting to discuss the recommendation when the parent disagrees with the assessor's mental health service recommendation. (Cal. Code Regs., tit. 2, § 60045, subd. (f).)

10) The county of origin shall prepare yearly IEP reassessments to determine the needs of a pupil. (Cal. Code Regs., tit. 2, § 60045, subd. (h).)

C. Transfers and Interim Placements (Cal. Code Regs., tit. 2, § 60055)

1) Following a pupil's transfer to a new school district, the county shall provide interim mental health services, as specified in the existing IEP, for thirty days, unless the parent agrees otherwise.

2) Participate as a member of the IEP team of a transfer pupil to review the interim services and make a determination of services.

D. Participate as a Member of the Expanded IEP Team When Residential Placement of a Pupil is Recommended (Gov. Code, § 7572.55; Cal Code Regs., tit. 2, § 60100)

1) When a recommendation is made that a child be placed in an out-of-state residential facility, the expanded IEP team, with the county as a participant, shall develop a plan for using less restrictive alternatives and in-state alternatives as soon as they become available, unless it is in the best educational interest of the child to remain in the out-of-state school. (Gov. Code, § 7572.55, subd. (c).)

2) The expanded IEP team, with the county as a participant, shall document the alternatives to residential placement that were considered and the reasons why they were rejected. (Cal. Code Regs., tit. 2, § 60100, subd. (c).)

3) The expanded IEP team, with the county as a participant, shall ensure that placement is in accordance with the admission criteria of the facility. (Cal. Code Regs., tit. 2, § 60100, subd. (j).)

4) When the expanded IEP team determines that it is necessary to place a pupil who is seriously emotionally disturbed in residential care, counties shall ensure that: (1) the mental health services are specified in the IEP in accordance with federal law, and (2) the mental health services are provided by qualified mental health professionals. (Cal. Code Regs., tit. 2, § 60100, subd. (i).)

E. Case Management Duties for Pupils Placed in Residential Care (Cal. Code Regs., tit. 2, §§ 60100, 60110)

1) Coordinate the residential placement plan of a pupil with a disability who is seriously emotionally disturbed as soon as possible after the decision has been made to place the pupil in residential placement. The residential placement plan shall include provisions, as determined in the pupil's IEP, for the care, supervision, mental health treatment, psychotropic medication monitoring, if required, and education of the pupil. (Cal. Code Regs., tit, 2, § 60110, subd, (b)(1).)

2) When the IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a community treatment facility, the lead case manager shall ensure that placement is in accordance with admission, continuing stay, and discharge criteria of the community treatment facility. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(3).)

3) Identify, in consultation with the IEP team's administrative designee, a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost-effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment. (Cal. Code Regs, tit. 2, §§ 60100, subd. (e), 60110, subd. (c)(2).)

4) Document the determination that no nearby placement alternative that is able to implement the IEP can be identified and seek an appropriate placement that is as close to the parents' home as possible. (Cal. Code Regs., tit. 2, § 60100, subd. (f).)

5) Notify the local educational agency that the placement has been arranged and coordinate the transportation of the pupil to the facility if needed. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(7).)

6) Facilitate placement authorization from the county's interagency placement committee pursuant to Welfare and Institutions Code section 4094.5, subdivision (e)(1), by presenting the case of a pupil with a disability who is seriously emotionally disturbed prior to placement in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(11).)

7) Evaluate every 90 days the continuing stay criteria, as defined in Welfare and Institutions Code section 4094, of a pupil placed in a community treatment facility every 90 days. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(8).)

8) Schedule and attend the next expanded IEP team meeting with the expanded IEP team's administrative designee within six months of the residential placement of a pupil with a disability who is seriously emotionally disturbed and every six months thereafter as the pupil remains in residential placement. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(10).)

F. Authorize Payments to Out-Of-Home Residential Care Providers (Cal. Code Regs., tit. 2, § 60200, subd. (e))

1) Authorize payments to residential facilities based on rates established by the Department of Social Services in accordance with Welfare and Institutions Code sections 18350 and 18356. This activity requires counties to determine that the residential placement meets all the criteria established in Welfare and Institutions Code sections 18350 through 18356 before authorizing payment.

G. Provide Psychotherapy or Other Mental Health Treatment Services (Cal. Code Regs., tit. 2, §§ 60020, subd. (i), 60050, subd. (b), 60200, subd. (c))

1) The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)

2) The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)

3) Provide case management services to a pupil when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

4) Provide case management services and individual or group psychotherapy services, as defined in Business and Professions Code section 2903, when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

5) *Beginning July 1, 2004*, provide mental health assessments, collateral services, intensive day treatment, and day rehabilitation services when required by the pupil's

IEP. These services shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

6) Provide medication monitoring services when required by the pupil's IEP. "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subds. (f) and (i).)

7) Notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of a service, or when the pupil is no longer participating in treatment. ((Cal. Code Regs., tit. 2, § 60050, subd. (b).)

(When providing psychotherapy or other mental health treatment services, the activities of ~~mental health assessments, collateral services, intensive day treatment, case management,~~ crisis intervention, vocational services, and socialization services are not reimbursable.)

V. CLAIM PREPARATION AND SUBMISSION

Each of the following cost elements must be identified for each reimbursable activity identified in section IV. of this document. Each claimed reimbursable cost must be supported by source documentation as described in section IV. Additionally, each reimbursement claim must be filed in a timely manner.

There are two satisfactory methods of submitting claims for reimbursement of increased costs incurred to comply with the mandate: the direct cost reporting method and the cost report method.

Direct Cost Reporting Method

A. Direct Cost Reporting

Direct costs are those costs incurred specifically for the reimbursable activities. The following direct costs are eligible for reimbursement.

1. Salaries and Benefits

Report each employee implementing the reimbursable activities by name, job classification, and productive hourly rate (total wages and related benefits divided by productive hours). Describe the specific reimbursable activities performed and the hours devoted to each reimbursable activity performed.

2. Materials and Supplies

Report the cost of materials and supplies that have been consumed or expended for the purpose of the reimbursable activities. Purchases shall be claimed at the actual price after deducting discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged on an appropriate and recognized method of costing, consistently applied.

3. Contracted Services

Report the name of the contractor and services performed to implement the reimbursable activities. If the contractor bills for time and materials, report the number of hours spent on the activities and all costs charged. If the contract is a fixed price, report the services that were performed during the period covered by the reimbursement claim. If the contract services are also used for purposes other than the reimbursable activities, only the pro-rata portion of the services used to implement the reimbursable activities can be claimed. Submit contract consultant and invoices with the claim and a description of the contract scope of services.

4. Fixed Assets and Equipment

Report the purchase price paid for fixed assets and equipment (including computers) necessary to implement the reimbursable activities. The purchase price includes taxes, delivery costs, and installation costs. If the fixed asset or equipment is also used for purposes other than the reimbursable activities, only the pro-rata portion of the purchase price used to implement the reimbursable activities can be claimed.

B. Indirect Cost Rates

Indirect costs are costs that are incurred for a common or joint purpose, benefiting more than one program, and are not directly assignable to a particular department or program without efforts disproportionate to the result achieved. Indirect costs may include (1) the overhead costs of the unit performing the mandate; and (2) the costs of the central government services distributed to the other departments based on a systematic and rational basis through a cost allocation plan.

Compensation for indirect costs is eligible for reimbursement utilizing the procedure provided in the Office of Management and Budget (OMB) Circular A-87. Claimants have the option of using 10% of labor, excluding fringe benefits, or preparing an Indirect Cost Rate Proposal (ICRP) if the indirect cost rate claimed exceeds 10%.

If the claimant chooses to prepare an ICRP, both the direct costs (as defined and described in OMB Circular A-87 Attachments A and B) and the indirect costs shall exclude capital expenditures and unallowable costs (as defined and described in OMB A-87 Attachments A and B). However, unallowable costs must be included in the direct costs if they represent activities to which indirect costs are properly allocable.

The distribution base may be (1) total direct costs (excluding capital expenditures and other distorting items, such as pass-through funds, major subcontracts, etc.), (2) direct salaries and wages, or (3) another base which results in an equitable distribution.

In calculating an ICRP, the claimant shall have the choice of one of the following methodologies:

1. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) classifying a department's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate which is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected; or

2. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) separating a department into groups, such as divisions or sections, and then classifying the division's or section's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate that is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected.

Cost Report Method

A. Cost Report Method

Under this claiming method, the mandate reimbursement claim is still submitted on the State Controller's claiming forms in accordance with claiming instructions. A complete copy of the annual cost report, including all supporting schedules attached to the cost report as filed with the Department of Mental Health, must also be filed with the claim forms submitted to the State Controller.

B. Indirect Cost Rates

To the extent that reimbursable indirect costs have not already been reimbursed by the Department of Mental Health from categorical funding sources, they may be claimed under this method.

Indirect costs are costs that are incurred for a common or joint purpose, benefiting more than one program, and are not directly assignable to a particular department or program without efforts disproportionate to the result achieved. Indirect costs may include (1) the overhead costs of the unit performing the mandate; and (2) the costs of the central government services distributed to the other departments based on a systematic and rational basis through a cost allocation plan.

Compensation for indirect costs is eligible for reimbursement utilizing the procedure provided in the Office of Management and Budget (OMB) Circular A-87. Claimants have the option of using 10% of labor, excluding fringe benefits, or preparing an Indirect Cost Rate Proposal (ICRP) if the indirect cost rate claimed exceeds 10%.

If the claimant chooses to prepare an ICRP, both the direct costs (as defined and described in OMB Circular A-87 Attachments A and B) and the indirect costs shall exclude capital expenditures and unallowable costs (as defined and described in OMB A-87 Attachments A and B). However, unallowable costs must be included in the direct costs if they represent activities to which indirect costs are properly allocable.

The distribution base may be (1) total direct costs (excluding capital expenditures and other distorting items, such as pass-through funds, major subcontracts, etc.), (2) direct salaries and wages, or (3) another base which results in an equitable distribution.

In calculating an ICRP, the claimant shall have the choice of one of the following methodologies:

1. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) classifying a department's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an

equitable distribution base. The result of this process is an indirect cost rate which is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected; or

2. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) separating a department into groups, such as divisions or sections, and then classifying the division's or section's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate that is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected.

VI. RECORDS RETENTION

Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district pursuant to this chapter[3] is subject to the initiation of an audit by the State Controller no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the Controller to initiate an audit shall commence to run from the date of initial payment of the claim. All documents used to support the reimbursable activities, as described in Section IV, must be retained during the period subject to audit. If an audit has been initiated by the Controller during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings.

VII. OFFSETTING SAVINGS AND REIMBURSEMENTS

Any offsetting savings the claimant experiences in the same program as a result of the same statutes or executive orders found to contain the mandate shall be deducted from the costs claimed. In addition, reimbursement for this mandate received from any of the following sources shall be identified and deducted from this claim:

1. Funds received by a county pursuant to Government Code section 7576.5.
2. Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes the appropriation made by the Legislature in the Budget Act of 2001, which appropriated funds to counties in the amounts of $12,334,000 (Stats. 2001, ch. 106, items 4440-131-0001), and the $69 million appropriations in 2003 and 2004 (Stats. 2003, ch. 157, item 6110-161-0890, provision 17; Stats. 2004, ch. 208, item 6110-161-0890, provision 10).
3. Private insurance proceeds obtained with the consent of a parent for purposes of this program.

[3] This refers to Title 2, division 4, part 7, chapter 4 of the Government Code.

4. Medi-Cal proceeds obtained from the state or federal government that pay for a portion of the county services provided to a pupil under the Handicapped and Disabled Students program in accordance with federal law.
5. Any other reimbursement received from the federal or state government, or other non-local source.

Beginning July 1, 2001, realignment funds under the Bronzan-McCorquodale Act that are used by a county for this program are not required to be deducted from the costs claimed. (Stats. 2004, ch. 493, § 6 (SB 1895).)

VIII. STATE CONTROLLER'S CLAIMING INSTRUCTIONS

Pursuant to Government Code section 17558, subdivision (b), the Controller shall issue claiming instructions for each mandate that requires state reimbursement not later than 60 days after receiving the adopted parameters and guidelines from the Commission, to assist local agencies and school districts in claiming costs to be reimbursed. The claiming instructions shall be derived from the statute or executive order creating the mandate and the parameters and guidelines adopted by the Commission.

Pursuant to Government Code section 17561, subdivision (d)(l), issuance of the claiming instructions shall constitute a notice of the right of the local agencies and school districts to file reimbursement claims, based upon parameters and guidelines adopted by the Commission.

IX. REMEDIES BEFORE THE COMMISSION

Upon request of a local agency or school district, the Commission shall review the claiming instructions issued by the State Controller or any other authorized state agency for reimbursement of mandated costs pursuant to Government Code section 17571. If the Commission determines that the claiming instructions do not conform to the parameters and guidelines, the Commission shall direct the Controller to modify the claiming instructions to conform to the parameters and guidelines as directed by the Commission.

In addition, requests may be made to amend parameters and guidelines pursuant to Government Code section 17557, subdivision (a), and the California Code of Regulations, title 2, section 1183.2.

X. LEGAL AND FACTUAL BASIS FOR THE PARAMETERS AND GUIDELINES

The Statement of Decision is legally binding on all parties and provides the legal and factual basis for the parameters and guidelines. The support for the legal and factual findings is found in the administrative record for the test claim. The administrative record, including the Statement of Decision, is on file with the Commission.

TAB 5

California Office of Administrative Law

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2 CA ADC § 1185

Term

2 CCR s 1185

Cal. Admin. Code tit. 2, s 1185

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
TITLE 2. ADMINISTRATION
DIVISION 2. FINANCIAL OPERATIONS
CHAPTER 2.5. COMMISSION ON STATE MANDATES
ARTICLE 5. INCORRECT REDUCTION CLAIMS
This database is current through 4/13/07, Register 2007, No. 15

s 1185. Incorrect Reduction Claim Filing.

(a) To obtain a determination that the Office of State Controller incorrectly reduced a reimbursement claim, a claimant shall file an "incorrect reduction claim" with the commission.

(b) All incorrect reduction claims shall be filed with the commission no later than three (3) years following the date of the Office of State Controller's remittance advice or other notice of adjustment notifying the claimant of a reduction.

(c) An incorrect reduction claim shall pertain to alleged incorrect reductions in a reimbursement claim (s) filed by one claimant. The incorrect reduction claim may be for more than one fiscal year.

(d) All incorrect reduction claims, or amendments thereto, shall be filed on a form provided by the commission.

(e) All incorrect reduction claims, or amendments thereto, shall contain at least the following elements and documents:

(1) A copy of the Office of State Controller's claiming instructions that were in effect during the fiscal year(s) of the reimbursement claim(s).

(2) A written detailed narrative that describes the alleged incorrect reduction(s). The narrative shall include a comprehensive description of the reduced or disallowed area(s) of cost(s).

(3) If the narrative describing the alleged incorrect reduction(s) involves more than discussion of statutes or regulations or legal argument and utilizes assertions or representations of fact, such assertions or representations shall be supported by testimonial

or documentary evidence and shall be submitted with the claim. All documentary evidence must be authenticated by declarations under penalty of perjury signed by persons who are authorized and competent to do so and be based upon the declarant's personal knowledge or information or belief.

(4) A copy of the final state audit report or letter or the remittance advice or other notice of adjustment from the Office of State Controller that explains the reason(s) for the reduction or disallowance.

(5) A copy of a letter sent by the claimant or the claimant's representative to the Office of State Controller explaining why the reduced area(s) of cost in dispute should be restored.

(6) A copy of the subject reimbursement claims the claimant submitted to the Office of State Controller.

(7) An incorrect reduction claim, or amendment thereto, shall be signed at the end of the document, under penalty of perjury by the claimant or its authorized representative, with the declaration that the test claim is true and complete to the best of the declarant's personal knowledge or information or belief. The date signed, the declarant's title, address, telephone number, and, if available, electronic mail address and facsimile number, shall be included.

(8) The claimant shall file one original incorrect reduction claim, or amendment thereto, and accompanying documents with commission. The original shall be unbound and single-sided, without tabs, and include a table of contents.

(9) The claimant shall also file two (2) copies of the incorrect reduction claim, or amendment thereto, and accompanying documents with the commission. The copies may be two-sided and shall not include tabs.

(f) Within ten (10) days of receipt of an incorrect reduction claim, commission staff shall notify the claimant if the incorrect reduction claim is complete or incomplete. Incorrect reduction claims will be considered incomplete if any of the elements required in subsections (d) through (f) of this section are illegible or not included. Incomplete incorrect reduction claims shall be returned to the claimant. If a complete incorrect reduction claim is not received by the commission with thirty (30) days from the date the incomplete claim was returned to the claimant, the commission shall deem the filing to be withdrawn.

<General Materials (GM) - References, Annotations, or Tables>

Note: Authority cited: Section 17527(g) and (h), Government Code. Reference: Sections 17551(b) and 17553, Government Code.

HISTORY

1. New Article 5 (Sections 1185 and 1185.1) filed 12-13-85; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 85, No.

50).

2. Amendment of Note filed 4-29-87; operative 5-29-87 (Register 87, No. 18).

3. Amendment of subsections (a), (b) and (c)(4)-(5) and Note filed 7-23-96; operative 7-23-96. Submitted to OAL for printing only (Register 96, No. 30).

4. Amendment of section and Note filed 9-13-99; operative 9-13-99. Submitted to OAL for printing only pursuant to Government Code section 17527 (Register 99, No. 38).

5. Amendment of article heading and amendment of section and Note filed 4-21-2003; operative 4-21-2003. Submitted to OAL for printing only pursuant to Government Code section 17527(g) (Register 2003, No. 17).

2 CCR s 1185, **2 CA ADC s 1185**
1CAC

2 CA ADC s 1185

END OF DOCUMENT

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Term

Doc 1 of 7

Cite List Docs In Sequence Table of Contents

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THOMSON WEST

COUNTY'S

INCORRECT REDUCTION CLAIM

FILED WITH THE

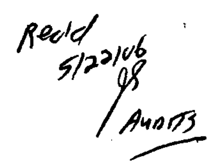
COMMISSION ON STATE MANDATES

ON MAY 1, 2006

STATE OF CALIFORNIA

ARNOLD SCHWARZENEGGER, *Governor*

COMMISSION ON STATE MANDATES
980 NINTH STREET, SUITE 300
SACRAMENTO, CA 95814
PHONE: (916) 323-3562
FAX: (916) 445-0278
E-mail: csminfo@csm.ca.gov



May 12, 2006

Ms. Bang Quan
County of Orange
Auditor-Controller
P.O. Box 567
Santa Ana, CA 92702

Ms. Ginny Brummels
Division of Accounting and Reporting
State Controller's Office
3301 C Street, Suite 501
Sacramento, CA 95816

Re: **Incorrect Reduction Claim**
Handicapped and Disabled Students, 05-4282-I-02
County of Orange, Claimant
Statutes 1984, Chapter 1747; Statutes 1985, Chapter 1274
Fiscal Years 1997-1998 and 1998-1999

Dear Ms. Quan and Ms. Brummels:

On May 1, 2006, the County of Orange filed an incorrect reduction claim (IRC) with the Commission on State Mandates (Commission) based on the *Handicapped and Disabled Students* program for fiscal years 1997-1998 and 1998-1999. Commission staff determined that the IRC filing is complete.

Government Code section 17551, subdivision (b), requires the Commission to hear and decide upon claims filed by local agencies and school districts that the State Controller's Office (SCO) has incorrectly reduced payments to the local agencies or school districts.

SCO Review and Response. Please file the SCO response and supporting documentation regarding this claim within 90 days of the date of this letter. Please include an explanation of the reason(s) for the reductions and the computation of reimbursements. All documentary evidence must be authenticated by declarations under penalty of perjury signed by persons who are authorized and competent to do so and be based on the declarant's personal knowledge, information or belief. The Commission's regulations also require that the responses (opposition or recommendation) filed with the Commission be simultaneously served on the claimants and their designated representatives, and accompanied by a proof of service. (Cal. Code Regs., tit. 2, § 1185.01.)

The failure of the SCO to respond within this 90-day timeline shall not cause the Commission to delay consideration of this IRC.

Claimant's Rebuttal. Upon receipt of the SCO response, the claimant and interested parties may file rebuttals. The rebuttals are due 30 days from the service date of the response.

Prehearing Conference. A prehearing conference will be scheduled if requested.

Public Hearing and Staff Analysis. The public hearing on this claim will be scheduled after the record closes. A staff analysis will be issued on the IRC at least eight weeks prior to the public hearing.

Dismissal of Incorrect Reduction Claims. Under section 1188.31 of the Commission's regulations, IRCs may be dismissed if postponed or placed on inactive status by the claimant for more than one year. Prior to dismissing a claim, the Commission will provide 60 days notice and opportunity for the claimant to be heard on the proposed dismissal.

Please contact Tina Poole at (916) 323-8220 if you have any questions.

Sincerely,

NANCY PATTON
Assistant Executive Director

Enclosure: Incorrect Reduction Claim Filing - (SCO only)

J:mandates/IRC/2005/4282-I-02/completeltr

06MAY16 PM 1:25

State of California
COMMISSION ON STATE MANDATES
980 Ninth Street, Suite 300
Sacramento, CA 95814
(916) 323-3562

For Official Use Only

RECEIVED
MAY 01 2006
COMMISSION ON STATE MANDATES

Claim No. 05-4282-I-02

INCORRECT REDUCTION CLAIM FORM

Local Agency or School District Submitting Claim

Auditor-Controller
County of Orange

Contact Person: Kim Engelby/Howard Thomas

Telephone No.: (714) 834-7407
(714) 834-5313

Address

515 Sycamore St, 5th Floor
Santa Ana, CA 92702

Representative Organization to be Notified

County of Orange, Auditor-Controller Financial Reporting and Mandated Costs

Attn: Bang Quan
PO Box 567
Santa Ana, CA 92702

This claim alleges an incorrect reduction of a reimbursement claim filed with the state Controller's Office pursuant to section 17561 of the Government Code. This incorrect reduction claim is filed pursuant to section 17551(b) of the Government Code.

CLAIM IDENTIFICATION: Specify Statute or Executive Order

Chapters 1747/84 & 1274/85 - Services to Handicapped Students

Fiscal Year*	Amount of the Incorrect Reduction
1997-98	$759,114
1998-99	$870,701
Total	$1,629,815

*More than one fiscal year may be claimed.

IMPORTANT: PLEASE SEE INSTRUCTIONS AND FILING REQUIREMENTS FOR COMPLETING AN INCORRECT REDUCTION CLAIM ON THE REVERSE SIDE.

Name and Title of Authorized Representative

Denise Steckler, Manager
Financial Reporting and Mandated Costs

Telephone No.: (714) 834-5367

Signature of Authorized Representative: Denise Steckler

Date: 4/28/06

COUNTY OF ORANGE
HEALTH CARE AGENCY

BEHAVIORAL HEALTH SERVICES

Excellence
Integrity
Service

JULIETTE A. POULSON, RN, MN
DIRECTOR

MARK A. REFOWITZ
DEPUTY AGENCY DIRECTOR
BEHAVIORAL HEALTH SERVICES

MAILING ADDRESS:
405 W. 5th STREET, 7th Floor
SANTA ANA, CA 92701

TELEPHONE: (714) 834-6032
FAX: (714) 834-5506
E-MAIL: mrefowitz @ochca.com

April 27, 2006 **CERTIFIED MAIL**

Paula Higashi, Executive Director
Commission on State Mandates
980 9th Street, Suite 300
Sacramento, CA 95814

Re: Incorrect Reduction Claim
Handicapped and Disabled SB90 Claim (HDS)
Fiscal Years 1997/98 and 1998/99

On May 2, 2003, the County of Orange received remittance advices totaling $1,791,058 resulting from findings from the State Controller Office's (SCO) audit of the County's SB90 *Handicapped and Disabled Students* (HDS) claims for Fiscal Years (FY) 1997/98 and 1998/99. Of this amount, $1,629,815 pertained to medication monitoring services that were at that time disallowed.

In our appeal to the findings of this audit, we cited several sections from the California Code of Regulations, Welfare and Institutions Code, and the Government Code that all mandate medication monitoring as a necessary part of treatment services provided for under Chapter 26.5 of the Government Code, and therefore were implied as claimable under the Parameters and Guidelines for this mandate at that time. The SCO's denial of this appeal was based on the argument that the Parameters and Guidelines specify all activities covered by the mandate, and by not specifically including medication monitoring, this implied that these services were not covered.

However, as a result of a successful HDS test claim by another entity, the Commission on State Mandates issued new parameters and guidelines for this claim on February 17, 2006 that allowed for the reimbursement of medication monitoring services. Based on this action, which validates that medication monitoring is and always has been a mandated activity, the County is thereby submitting this Incorrect Reduction Claim for the previously disallowed medication monitoring expenditures from FY 1997/98 and 1998/99 in the amount of $1,629,815 per Title 2, Division 2, Chapter 2.5, Article 1 of the California Code of Regulations.

In accordance with the claiming instructions, we have enclosed the required copies of the necessary documentation in support of this claim. If you require additional information or have any questions, please contact my office at (714) 834-6032.

Mark A. Refowitz
Deputy Agency Director
Behavioral Health Services

Attachments

MAR/ke

EXHIBIT A

SERVICES TO HANDICAPPED STUDENTS

1. Summary of Chapters 1747/84 and 1274/85

Chapter 1747, Statutes of 1984, added Chapter 26, commencing with § 7570, to Division 7 of Title 1 of the Government Code.

Chapter 1274, Statutes of 1985, amended Government Code § § 7572, 7572.5, 7575, 7576, 7579, 7582, and 7587; amended and repealed § 7583; added § 7586.5 and 7586.7; repealed § 7574 and amended § 5651 of the Welfare and Institutions Code. To the extent that Government Code § 7572 and § 60040, Title 2, Code of California Regulations, require county participation in the mental health assessment for "individuals with exceptional needs," such legislation and regulations impose a new program or higher level of service upon a county. Furthermore, any related county participation in the expanded "Individualized Education Program" (IEP) team and case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed", pursuant to Subdivisions (a), (b), and (c) of Government Code § 7572.5 and their implementing regulations.

The aforementioned mandatory county participation in the IEP process is not subject to the Short Doyle Act, and accordingly, such costs related thereto, are costs mandated by the state and are fully reimbursable within the meaning of § 6, Article XIIIB of the California Constitution.

The provisions of Welfare and Institutions Code § 5651, Subdivision (g), result in a higher level of service within the county Short-Doyle program because pursuant to Government Code § § 7571 and 7576 and their implementing regulations, the mental health services must be included in the county Short-Doyle annual plan. Such services include psychotherapy and other mental health services provided to "individuals with exceptional needs", including those designated as "seriously emotionally disturbed", and required in such individual's IEP.

Such mental health services are subject to the current cost sharing formula of the Short-Doyle Act, through which the state provides ninety (90) percent of the total costs of the Short-Doyle program, and the county is required to provide the remaining ten (10) percent of the funds. Accordingly, only ten (10) percent of such program costs are reimbursable within the meaning of § 6, Article XIIIB of the California Constitution as costs mandated by the state, because the Short-Doyle Act currently provides counties ninety (90) percent of the costs of furnishing those mental health services set forth in Government Code § § 7571 and 7576 and their implementing regulations, and described in the county's Short-Doyle annual plan pursuant to Welfare and Institutions Code § 5651, Subdivision (g).

On April 26, 1990, the Commission on State Mandates determined that Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 resulted in state mandated costs that are reimbursable pursuant to Part 7 (commencing with Government Code § 17500) of Division 4 of Title 2. The Commission determined that county participation in the IEP process is a state mandated program and any related cost is fully reimbursable. Furthermore, any mental health treatment required by an IEP is subject to the Short-Doyle cost sharing formula. Consequently, only the county's Short-Doyle share (i.e., ten percent) of the mental health treatment costs will be reimbursed as costs mandated by the state.

2. Eligible Claimants

Any county incurring increased costs as a result of this mandate is eligible to claim reimbursement of these costs.

3. Appropriations

These claiming instructions are issued following the adoption of the program's amended parameters and guidelines by the Commission on State Mandates. Funds for payment of the 1994/95, 1995/96, 1996/97 costs are made available in state budget acts of these fiscal years.

To determine if this program is funded in subsequent fiscal years, refer to the schedule "Appropriations for State Mandated Cost Programs" in the "Annual Claiming Instructions for State Mandated Costs" issued in September of each year to county auditors.

4. Types of Claims

A. Reimbursement and Estimated Claims

A claimant may file a reimbursement and/or an estimated claim. A reimbursement claim details the costs actually incurred for a prior fiscal year. An estimated claim shows the costs to be incurred for the current fiscal year.

B. Minimum Claim

Government Code § 17564(a) provides that no claim shall be filed pursuant to Government Code § 17561 unless such a claim exceeds $200 per program per fiscal year.

5. Filing Deadline

A. Initial Claims

Initial claims must be filed within 120 days from the issuance date of claiming instructions. Accordingly:

(1) Reimbursement claims detailing the actual costs incurred for the 1994/95 and 1995/96 fiscal years must be filed with the State Controller's Office and post- marked by July 28, 1997. If the reimbursement claim is filed after the deadline of July 28, 1997, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

(2) Estimated claims for costs to be incurred during the 1996/97 fiscal year must be filed with the State Controller's Office and postmarked by July 28, 1997. Timely filed estimated claims are paid before late claims. If a payment is received for the estimated claim, a 1996/97 reimbursement claim must be filed by November 30, 1997.

B. Annually Thereafter

Refer to the item "Reimbursable State Mandated Cost Programs" contained in the annual cover letter for mandated cost programs issued annually in September, which identifies the fiscal years for which claims may be filed. If an "x" is shown for the program listed under "19__/19__ Reimbursement Claim," and/or "19__/19__ Estimated Claim," claims may be filed as follows:

(1) An estimated claim must be filed with the State Controller's Office and postmarked by November 30 of the fiscal year in which costs are to be incurred. Timely filed estimated claims will be paid before late claims.

After having received payment for an estimated claim, the claimant must file a reimbursement claim by November 30 of the following fiscal year. If the local agency fails to file a reimbursement claim, monies received for the estimated claim must be returned to the State. If no estimated claim was filed, the agency may file a reimbursement claim detailing the actual costs incurred for the fiscal year, provided there was an appropriation for the program for that fiscal year. For information regarding appropriations for reimbursement claims, refer to the "Appropriation for State Mandated Cost Programs" in the previous fiscal year's annual claiming instructions.

(2) A reimbursement claim detailing the actual costs must be filed with the State Controller's Office and postmarked by November 30 following the fiscal year in which costs were incurred. If the claim is filed after the deadline but by November 30 of the succeeding fiscal year, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

6. Reimbursable Components

Eligible claimants will be reimbursed for the direct and indirect cost of labor, supplies, and services incurred for the following mandated components:

A. Assessment, IEP Participation, Case Management

(1) The scope of the mandate is one hundred percent (100) percent reimbursement of any costs related to IEP Participation, Assessment, and Case Management, except for individuals billed to Medi-Cal only. The Federal Financing Participation portion (FFP) for these activities should be deducted from reimbursable activities not subject to the Short-Doyle Act.

(2) For each eligible claimant, the following cost items are one hundred (100%) percent reimbursable (G. C. § 7572, subd. (d)(1)):

(a) Whenever an LEA refers an individual suspected of being an "individual with exceptional needs" to the local mental health department, mental health assessment and recommendation by qualified mental health professionals in conformance with assessment procedures set forth in Article 2 (commencing with § 56320) of Chapter 4 of part 30 of Division 4 of the Education Code, and regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, including but not limited to the following mandated services:

i. Interview with the child and family

ii. Collateral interviews as necessary

iii. Review of the records

iv. Observation of the child at school

v. Psychological testing and/or psychiatric assessment, as necessary.

(b) Review and discussion of mental health assessment and recommendations with parent and appropriate IEP team members. (G. C. § 7572, subd. (d)(1)).

(c) Attendance by the mental health professional who conducted the assessment at IEP meetings, when requested. (G. C. § 7572, subd. (d)(1)).

(d) Review by claimant's mental health professional of any independent assessment(s) submitted by the IEP team. (G. C. 7572, subd. (d)(2)).

(e) When the written mental health assessment report provided by the local mental health program determines that an "individual with special needs" is seriously

emotionally disturbed", and any member of the IEP team recommends residential placement based upon relevant assessment information, inclusion of the claimant's mental health professional on that individual's expanded IEP team.

(f) When the IEP prescribes residential placement for an "individual with exceptional needs" who is "seriously emotionally disturbed," claimant's mental health personnel's identification of out-of-home placement, case management, six month review of IEP, and expanded IEP responsibilities. (G. C. § 7572.5).

(g) Required participation in due process procedures, including but not limited to due process hearings.

(b) One hundred (100%) percent of any administrative costs related to IEP Participation, Assessment, and Case Management, whether direct or indirect.

B. Treatment Services

Any costs related to mental health treatment services rendered under the Short-Doyle Act:

(1) The scope of the mandate is ten (10%) percent reimbursement.

(2) For each eligible claimant, the following cost items for the provision of mental health services when required by a child's individualized education program are ten (10%) percent reimbursable (G. C. § 7576):

(a) Individual therapy

(b) Collateral therapy and contacts

(c) Group therapy

(d) Day treatment

(e) Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.

(b) Ten (10%) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

7. Reimbursement Limitations

A. Any offsetting savings the claimant experiences as a direct result of this statute must be deducted from the costs claimed.

B. The following reimbursements for this mandate shall be deducted from the claim:

1. Any direct payments (categorical funding) received form the State which are specifically allocated to this program.
2. Any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g., federal, state, etc.

8. Claiming Forms and Instructions

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms HDS-1, HDS-2, HDS-3, HDS-4, HDS-5, and HDS-6 provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions should be duplicated and used by the claimant to file estimated or reimbursement claims. The State Controller's Office will revise the manual and claim forms as necessary. In such instances, new replacement forms will be mailed to claimants.

9. **Claim Preparation**

There are two satisfactory methods of submitting claims for reimbursement of increased costs incurred to comply with the mandate:

A. **Cost Report Method**

Under this claiming method a complete copy of the annual cost report including all supporting schedules attached to the cost report as filed with DMH must also be filed with the claim forms submitted to the State Controller.

To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions:

Ten (10%) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs that exceed ten (10%) percent of total program direct labor costs, excluding fringe benefits.

OR if an indirect cost rate greater than ten (10%) is being claimed:

By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations that further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program, each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP's.

1. **Form HDS-6, Component/Activity Cost Detail**

   This form is used to detail the cost of administration for Assessment, IEP Participation, Case Management and Mental Health Treatment. The indirect costs summarized on this form must be carried forward to HDS-3, line (03)(e) or HDS-3, line (03)(g), as appropriate.

   Indirect costs may be computed as ten (10%) of direct labor costs, excluding fringe benefits. If an indirect cost rate greater than ten (10%) is used, include the Indirect Cost Proposal (ICRP) with the claim. If more than one department is involved in the mandated costs program, each department must have their own ICRP.

2. **Form HDS-5, Component/Activity Cost Detail**

   This form is used to detail the cost of due process proceedings. Claim statistics shall identify the amount of work performed during the period in which costs are claimed. The claimant must provide the number of due process proceedings. The cost summarized on this form must be carried forward to HDS-3, line (03)(d).

   Indirect costs may be computed as ten (10%) of direct labor costs, excluding fringe benefits. If an indirect cost rate greater than ten (10%) is used, include the Indirect Cost Proposal (ICRP) with the claim. If more than one department is involved in the mandated costs program, each department must have their own ICRP.

3. **Form HDS-4, Component/Activity Cost Detail**

   This form is used to segregate the detailed cost by claim component. Information required to complete this form: (a) Name of Providers, (b) Provider I.D. Numbers, (c) Service Function Codes, (d) Units of Service, and (e) Rate Per

Unit. Carry forward the total from line (05) column (f) to form HDS-3, block (03) in the appropriate line.

4. **Form HDS-3, Claim Summary**

This form is used to summarize the cost from forms HDS-4, HDS-5, and HDS-6. The cost must be reduced by the amount of funds received from Non-Categorical State General/Realignment Funds, State Categorical Funds, Short-Doyle/Medi Cal (FFP only), and other funds that reimburse any portion of the mandate. The total claimed amount on this form is carried forward to form FAM-27.

B. **Actual Increased Cost Method**

Report actual increased costs incurred for each of the following expense categories in the format specified by the State Controller's claiming instructions. Attach supporting schedules as necessary.

1. **Form HDS-2, Component/Activity Cost Detail**

This form is used to segregate the detailed cost by claim component. A separate form HDS-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(a) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed by each employee and specify the actual time spent, the productive hourly rate and related fringe benefits.

Source documents required to be maintained by the claimant may include, but are not limited to, employee time records that show the employee's actual time spent on this mandate.

(b) Materials and Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of materials consumed or expended specifically for the purpose of this mandate.

Source documents required to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase orders and other documents evidencing the validity of the expenditures.

(c) Contracted Services

Contracting costs are reimbursable to the extent that the function to be performed requires special skill or knowledge that is not readily available from the claimant's staff or the service to be provided by the contractor is cost effective. Use of contract services must be justified by the claimant.

Give the name(s) of the contractor(s) who performed the services. Describe the activities performed by each named contractor, actual time spent on this mandate, inclusive dates when services were performed, and itemize all costs for services performed. Attach consultant invoices with the claim.

Source documents required to be maintained by the claimant may include, but are not limited to, contracts, invoices, and other documents evidencing the validity of the expenditures.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

2. Form HDS-1, Claim Summary

This form is used to summarize direct costs by cost component and compute allowable indirect costs for the mandate. Direct costs summarized on this form are derived from form HDS-2 and carried forward to form FAM-27.

One hundred (100%) of any indirect administrative costs related to IEP participation, assessment, case management, and ten percent (10%) of mental health treatment rendered under the Short-Doyle Act may be claimed to the extent that reimbursable indirect costs have not already been reimbursed by the DMH. Indirect costs may be claimed using either of two methods:

(a) Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs which exceed ten (10) percent of total program direct labor costs, excluding fringe benefits.

OR if an indirect cost rate greater than ten (10) percent is being claimed,

(b) By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program, each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP's.

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the local agency. All applicable information from form HDS-1 or HDS-3 must be carried forward to this form for the State Controller's Office to process the claim for payment.

Illustration of Claim Forms

A. Cost Report Method

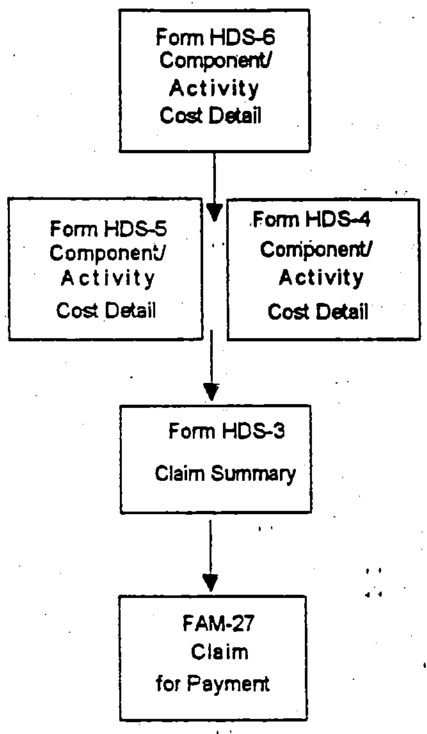
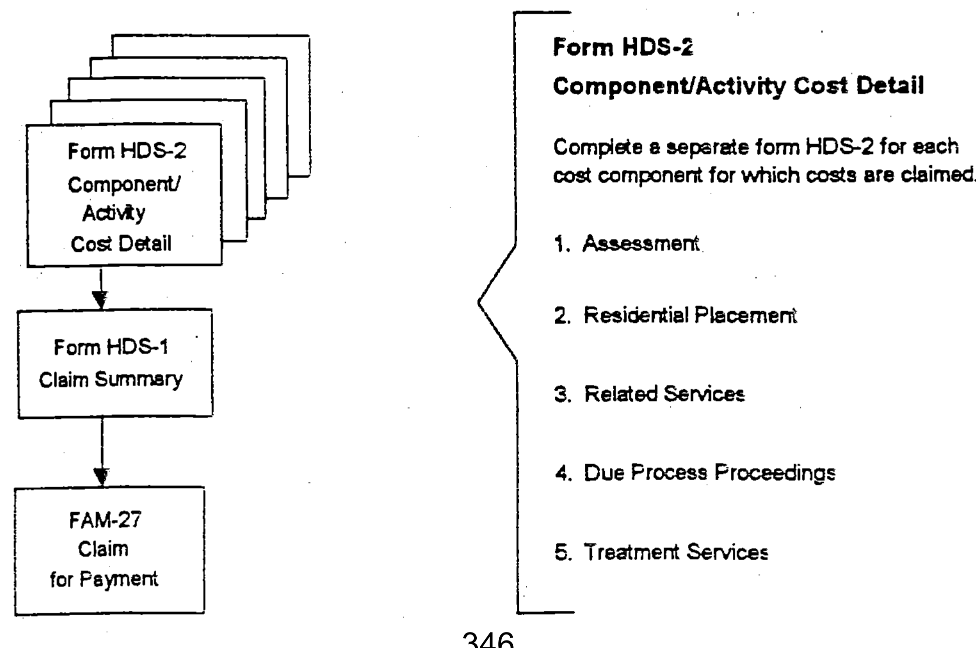


Illustration of Claim Forms

B. Actual Report Method



CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SERVICES TO HANDICAPPED STUDENTS

For State Controller Use Only
(19) Program Number 00111
(20) Date File ____/____/____
(21) LRS Input ____/____/____

LABEL HERE

(01) Claimant Identification Number
(02) Mailing Address
Claimant Name
County of Location
Street Address or P. O.. Box
City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 19___/19___	(12) 19___/19___
Total Claimed \mount	(07)	(13)
Less: 10% Late Penalty, not to exceed $1,000		(14)
Less: Estimated Claim Payment Received		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data	
(22) HDS-1, (03)(a)	
(23) HDS-1, (03)(b)	
(24) HDS-1, (03)(c)	
(25) HDS-1, (04)(1)(d)	
(26) HDS-1, (04)(2)(d)	
(27) HDS -1, (04)(3)(d)	
(28) HDS-1, (04)(4)(d)	
(29) HDS-1, (04)(5)(d)	
(30) HDS-1, (06)	
(31) HDS-3, (05)	
(32) HDS-3, (06)	
(33) HDS-3, (07)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 set forth on the attached statements.

Signature of Authorized Representative ____________________ Date ____________________

____________________ ____________________

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number ( ) Ext.

SERVICES TO HANDICAPPED STUDENTS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form HDS-1 and enter the amount from line (11) or complete form HDS-3 and enter the amount from line (15).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form HDS-1, line (11) or from form HDS-3, line (15), as appropriate.

(14) Filing Deadline. Amended Claims of Ch.1747/84 and Ch.1274/85. If the reimbursement claim for the 1994/95 or 1995/96 fiscal year is filed after July 28, 1997, the additional amount over the original claim must be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

Filing Deadline. Annually Thereafter. If the reimbursement claim is filed after November 30 following the fiscal year in which costs were incurred, the claim must be reduced by a late penalty.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (33) for the reimbursement claim [e.g., HDS-1 (03)(a), means the information is located on form HDS-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). The claim cannot be processed for payment unless this data block is correct and complete.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND ONE COPY OF FORM FAM-27, AND ONE COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by:
U.S. Postal Service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursement Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by:
Other delivery service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursement Section
Division of Accounting and Reporting
3301 C Street, Suite 501
Sacramento, CA 95816

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
CLAIM SUMMARY

FORM HDS-1

(01) Claimant	(02) Type of Claim Reimbursement ☐ Estimated ☐	Fiscal Year 19___/19___

Claim Statistics

(03)(a) Number of students who were suspected of being "individuals with exceptional needs," and were referred to the local mental health department for assessment and recommendation in the fiscal year of claim.	
(b) Number of students who required residential placements in the fiscal year of claim.	
(c) Number of due process proceedings that took place in the fiscal year of claim.	

Direct Costs

(04) Reimbursable Components:	(a) Salaries	(b) Benefits	(c) Services and Supplies	(d) Total
1. Assessment				
2. Residential Placement				
3. Related Services				
4. Due Process Proceedings				
5. Treatment Services				
(05) Total Direct Costs				

Indirect Costs

(06) Indirect Cost Rate	[From ICRP]	%
(07) Total Indirect Costs	[Line (06) x line (05)(a)] or [line (06) x [line (05)(a) + line (05)(b)]]	
(08) Total Direct and Indirect Costs	[Line (05)(d) + line (07)]	

Cost Reduction

(09) Less: Offsetting Savings, if applicable		
(10) Less: Other Reimbursements, (i.e., State General/Realignment Funds, State Categorical Funds, Short-Doyle/Medi-Cal (FFP only), etc.)		
(11) Total Claimed Amount	[Line (08) - {Line (09) + line (10)}]	

SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY Instructions	FORM HDS-1

(01) Enter the name of the claimant. If more than one department has incurred costs for this mandate, give the name of each department. A form HDS-1 should be completed for each department

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form HDS-1 must be filed for a reimbursement claim. Do not complete form HDS-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form HDS-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) (a) Enter the number of students who were suspected of being "individuals with exceptional needs," and were referred to the local mental health department for assessment and recommendation in the fiscal year of claim.
(b) Enter the number of students who required residential placements in the fiscal year of claim.
(c) Enter the number of due process proceedings that took place in the fiscal year of claim.

(04) Reimbursable Components: For each reimbursable component , enter the totals from form HDS-2, line (05) columns (d), (e), and (f) to form HDS-1, block (04) columns (a), (b), and (c) in the appropriate row. Total each row.

(05) Total Direct Costs. Total columns (a) through (d).

(06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.

(07) Total Indirect Costs. Multiply Total Salaries, line (05)(a) by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply total Salaries and Benefits, line (05)(a) and line (05)(b) by the Indirect Cost Rate, line (06).

(08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(d) and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source, [i.e., State General/Realignment Funds, State Categorical Funds, Short-Doyle/Medi-Cal (FFP only), service fees collected, federal funds, other state funds, etc.,] which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09) and Other Reimbursements, line (10) from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL

FORM HDS-2

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Check **only** one box per form to identify the component being claimed

- [ ] Assessment
- [ ] Due Process Proceedings
- [ ] Residential Placement
- [ ] Treatment Services
- [ ] Related Services

(04) Description of Expenses: Complete columns (a) through (f).

(a) Employee Names, Job Classifications, Functions Performed and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	Object Accounts (d) Salaries	(e) Benefits	(f) Services and Supplies
(05) Total [ ] Subtotal [ ] Page:_____ of_____					

SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL
Instructions

FORM HDS-2

(01) Enter the name of the claimant. If more than one department has incurred costs for this mandate, give the name of each department. A form HDS-2 should be completed for each department.

(02) Enter the fiscal year in which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form HDS-2 shall be prepared for each component which applies.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in line (03), enter the employee names, position titles, a brief description of their activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contracted services, etc. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed. If the descriptions are incomplete, the claim cannot be processed for payment.** For audit purposes, all supporting documents must be retained by the claimant for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub-object Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name Title	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits	Activities Performed	Benefit Rate		Salaries	Benefits = Benefit Rate x Salaries		
Services and Supplies Office Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Consumed	
Contracted Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Itemize Cost of Services Performed	Invoice

(05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed for the component/activity, number each page. Enter totals from line (05), columns (d), (e), and (f) to form HDS-1, block (04), columns (a), (b), and (c) in the appropriate row.

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY	FORM HDS-3

(01) Claimant	(02) Type of Claim Reimbursement ☐ Estimated ☐	Fiscal Year 19___/19___

(03) Reimbursable Components	
Assessment of Individuals With Exceptional Needs	
(a) Assessment: Interviews, Review of Records, Observations, Testing, etc.	
(b) Residential Placement: IEP Reviews, Case Management, and Expanded IEP	
(c) Related Services: Attendance at IEP meetings, Meeting with IEP Members and Parents, and Review of Independent Assessment.	
(d) Due Process Proceedings	
(e) Administrative Costs	
Mental Health Treatment	
(f) Treatment Services: Short-Doyle Program	
(g) Administrative Costs	
(04) Sub-total for Assessment of Individual with Exceptional Needs [Sum of (03), lines (a) to (e)]	
(05) Less: Amount Received from Short-Doyle/Medi-Cal (FFP only)	
(06) Less: Amount Received from State Categorical Funding	
(07) Less: Amount Received from Other (Identify)	
(08) Total for Assessment of Individual with Exceptional Needs [Line (04) minus the sum of lines (05) to (07)]	
(09) Sub-Total for Mental Health Treatment [block (03), lines (f) and (g)]	
(10) Less: Non-Categorical State General/Realignment Funds	
(11) Less: Amount Received from State Categorical Funds	
(12) Less: Amount Received from Short-Doyle/Medi-Cal (FFP only)	
(13) Less: Amount Received from Other (Identify)	
(14) Total Mental Health Treatment [Line (09) minus the sum of lines (10) to (13)]	
(15) Total Claimed Amount [Sum of line (08) and line (14)]	

SERVICES TO HANDICAPPED STUDENTS CLAIM SUMMARY Instructions	FORM HDS-3

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form HDS-3 must be filed for a reimbursement claim. Do not complete form HDS-3 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form HDS-3 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Reimbursable Components. For each reimbursable component under block (03), lines (a), (b), and (c), enter the totals from form HDS-4, line (05) column (f), as applicable. For block (03), line (d), enter the cost from form HDS-5, line (08), if applicable. For block (03), lines (e) and (g), enter the cost from HDS-6, line (08), as appropriate.

(04) Sub-Total for Assessment of Individual with Exceptional Needs. Enter the sum of the amounts on block (03), lines (a), (b), (c), (d), and (e).

(05) Less: Amount Received from Short-Doyle/Medi-Cal (Federal Financial Participation only). From line 72, "Medi-Cal Federal", the Department of Mental Health Cost Reporting/Data Collection System, "Local Services Cost Report", form MH 1944, enter the sum of amounts shown for providers listed on form HDS-4, block (04)(a).

(06) Less: Amount Received from State Categorical Funding. Enter the total amount received from the State General Fund for special education.

(07) Less: Amount Received from Other (Identify). Enter the total amount received from sources which reimbursed the cost of this mandate (e.g., Patient health insurance, etc.). Attach a separate schedule identifying those funding sources.

(08) Total for Assessment of Individual with Exceptional Needs. Enter the result of subtracting the sum of lines (05), (06), and (07) from line (04).

(09) Sub-Total for Mental Health Treatment. Enter the sum of the amount from block (03), lines (f) and (g).

(10) Less: Non-Categorical State General/Realignment Funds.

(11) Less: Amount Received from State Categorical Funds. Enter the total amount received from the State General Fund for special education.

(12) Less: Amount Received from Short-Doyle/Medi-Cal (Federal Financial Participation only). From line 72 , "Medi-Cal Federal", the Department of Mental Health Cost Reporting/Data Collection System, "Local Services Cost Report", form MH 1944, enter the sum of amounts shown for providers listed on form HDS-4, block (04)(a).

(13) Less: Amount Received from Other (Identify). Enter the total amount received from sources which reimbursed the cost of this mandate (e.g., Patient health insurance). Attach a separate schedule identifying those funding.

(14) Total Mental Health Treatment. Enter the result of subtracting the sum of lines (10) to (13) from line (09).

(15) Total Claimed Amount. Enter the sum of line (08) and line (14). Carry forward the amount on this line to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL

FORM HDS-4

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Check **only** one box per form to identify the component being claimed

☐ Assessment

☐ Treatment Services

☐ Residential Placement

☐ Other (Identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I. D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total

(05) Total ☐ Subtotal ☐ Page: ______ of ______

SERVICES TO HANDICAPPED STUDENTS COMPONENT/ACTIVITY COST DETAIL Instructions	FORM HDS-4

(01) Enter the name of the claimant.

(02) Enter the fiscal year of claim in which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form HDS-4 shall be prepared for each component which applies.

(04) Description of Expenses. For each "checked" component/activity box in block (03), enter the detailed costs for each case claimed.

(a) Enter the name of the provider.

(b) Enter the provider identification number.

(c) Enter the service function codes.

(d) Enter the number of units of service.

(e) Enter the rate per unit.

(f) Enter the total [multiply column (d) times column (e)]

A copy of that portion of the county's Short-Doyle fiscal year end report relating to the amounts claimed must be submitted with the claim.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

(05) Total line (04) column (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/activity costs, number each page. Carry forward the total from line (05) column (f) to form HDS-3, block (03) in the appropriate line.

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL

FORM HDS-5

(01) Claimant	(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Due Process Proceedings

(04) Description of Expenses: Complete columns (a) through (g).			Object Accounts			
(a) Employee Names, Job Classifications, Functions Performed and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Totals						
(05) Total Direct Costs						

Indirect Costs

(06) Indirect Cost Rate	[From ICRP]	%
(07) Total Indirect Costs	[Line (06) x line (05)(d)] or [Line (06) x {(05)(d) + (05)(e)}]	
(08) Total Direct and Indirect Costs	[Line (05) + line (07)]	

SERVICES TO HANDICAPPED STUDENTS COMPONENT/ACTIVITY COST DETAIL Instructions	FORM HDS-5

(01) Enter the name of the claimant.

(02) Enter the fiscal year in which costs were incurred.

(03) Reimbursable Components. Due Process Proceedings.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in line (03), enter the employee names, position titles, a brief description of their activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contracted services, etc. Total each column (d) through (g). **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed. If the descriptions are incomplete, the claim cannot be processed for payment.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns							Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	
Salaries	Employee Name Title	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked				
Benefits	Activities Performed	Benefit Rate		Salaries	Benefits = Benefit Rate x Salaries			
Services and Supplies Office Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Consumed		
Contracted Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service				Itemized Cost of Services Performed	Invoice

(05) Total Direct Costs. Enter the total for columns (d) to (g).

(06) Indirect Cost Rate. Enter the indirect cost rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the department's Indirect Cost Rate Proposal (ICRP) for the program with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.

(07) Total Indirect Costs. Multiply Total Salaries, line (04)(d) by the Indirect Cost Rate, line (06). If both salaries and benefits are used in the distribution base for the computation of the indirect cost rate, then multiply Total Salaries, line (04)(d) and Total Benefits, line (04)(e) by the Indirect Cost Rate, line (06).

(08) Total Direct and Indirect Costs. Enter the sum of line (05) and line (07). Forward the amount to form HDS-1, line (03)(d).

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT/ACTIVITY COST DETAIL

FORM HDS-6

(01) Claimant	(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Components: Administrative Costs

☐ Assessment of Individual ☐ Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).

(a) Employee Names, Job Classifications, Functions Performed and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	Object Accounts (d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Totals						

(05) Total Direct Costs	

Indirect Costs

(06) Indirect Cost Rate	[From ICRP]	%
(07) Total Indirect Costs	[Line (06) x line (04)(d)] or [Line (06) x {(04)(d) + (04)(e)}]	

SERVICES TO HANDICAPPED STUDENTS COMPONENT/ACTIVITY COST DETAIL Instructions	FORM HDS-6

(01) Enter the name of the claimant.

(02) Enter the fiscal year in which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the administrative cost component (i.e., Assessment of Individuals or Mental Treatment) claimed. A separate form HDS-6 shall be prepared for administrative costs associated with the assessment of individuals with exceptional needs, and for mental health treatment.. Do not include indirect costs for line (03)(d), since the cost should be recorded on form HDS-5.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in line (03), enter the employee names, position titles, a brief description of their activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contracted services, etc. Total each column (d) through (g). **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed. If the descriptions are incomplete, the claim cannot be processed for payment.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns							Submit these supporting documents
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked				
Benefits	Title	Benefit Rate		Salaries	Benefits = Benefit Rate x			
Services and Supplies Office Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity		
Contracted Services	Name of Contractor Specific Tasks	Hourly Rate	Hours Worked Inclusive Dates of				Itemized Cost of Services Performed	Invoice

(05) Total Direct Costs. Enter the total for columns (d) to (g).

(06) Indirect Cost Rate. Enter the indirect cost rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the department's Indirect Cost Rate Proposal (ICRP) for the program with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.

(07) Total Indirect Costs. Multiply Total Salaries, line (04)(d) by the Indirect Cost Rate, line (06). If both salaries and benefits are used in the distribution base for the computation of the indirect cost rate, then multiply Total Salaries, line (04)(d) and Total Benefits, line (04)(e) by the Indirect Cost Rate, line (06). Forward the amount of indirect costs to form HDS-3, line (03)(e) or line (03)(g) as appropriate.

EXHIBIT B

ORANGE COUNTY

Audit Report

HANDICAPPED AND DISABLED STUDENTS PROGRAM

Chapter 1747, Statutes of 1984, and
Chapter 1274, Statutes of 1985

July 1, 1997, through June 30, 1999

KATHLEEN CONNELL
California State Controller

December 2002

KATHLEEN CONNELL
Controller of the State of California

December 26, 2002

The Honorable David E. Sundstrom
Auditor-Controller
Orange County
12 Civic Center Plaza
Santa Ana, CA 92701

Dear Mr. Sundstrom:

The State Controller's Office (SCO) has completed an audit of the claims filed by Orange County for costs of the legislatively mandated Handicapped and Disabled Students Program (Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985) for the period of July 1, 1997, through June 30, 1999.

The county claimed and was paid $22,506,432 for the mandated program. The SCO audit disclosed that $20,715,374 is allowable and $1,791,058 is unallowable. The unallowable costs resulted primarily from the county claiming ineligible costs, which caused an overstatement in the county's Medi-Cal revenue offsets. Consequently, the amount paid in excess of allowable costs claimed, totaling $1,791,058, should be returned to the State.

The above amounts incorporate the fiscal effect of Assembly Bill 2781 (Chapter 1167, Statutes of 2002). The legislation changed the regulatory criteria by stating that the percentage of treatment costs claimed by counties for fiscal year 2000-01 and prior fiscal years is not subject to dispute by the SCO. Consequently, AB 2781 reduced realignment funding and, therefore, increased net reimbursable costs by $10,522,121.

The SCO has established an informal audit review process to resolve a dispute of facts. The auditee should submit, in writing, a request for a review and all information pertinent to the disputed issues within 60 days after receiving the final report. The request and supporting documentation should be submitted to: Richard J. Chivaro, Chief Counsel, State Controller's Office, Post Office Box 942850, Sacramento, CA 94250-0001.

If you have any questions, please contact Jim L. Spano, Chief, Compliance Audits Bureau, at (916) 323-5849.

Sincerely,

WALTER BARNES
Chief Deputy State Controller, Finance

WB:wq/jj

cc: Shawn Skelly
Assistant Auditor-Controller
Orange County
Douglas E. Barton, Director
Behavioral Health Department
Orange County
Alice Manning, Deputy Director
Behavioral Health Department
Orange County

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Audit Report

Summary

The State Controller's Office (SCO) has completed an audit of the claims filed by Orange County for costs of the legislatively mandated Handicapped and Disabled Students Program (Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985) for the period of July 1, 1997, through June 30, 1999. The last day of fieldwork was June 19, 2002.

The county claimed and was paid $22,506,432 in program costs for the audit period. The SCO audit disclosed that $20,715,374 is allowable and $1,791,058 is unallowable. The unallowable costs resulted primarily from the county claiming ineligible costs, which caused an overstatement in the county's Medi-Cal revenue offsets. The amount paid in excess of allowable costs claimed, totaling $1,791,058, should be returned to the State.

Background

Chapter 1747, Statutes of 1984, requires counties to participate in the mental health assessment for "individuals with exceptional needs," participate in the expanded Individualized Education Program (IEP) team, and provide case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed." These requirements impose a new program or a higher level of service upon counties. On April 26, 1990, the Commission on State Mandates determined that Chapter 1747, Statutes of 1984, resulted in state-mandated costs that are reimbursable pursuant to *Government Code* Section 17561.

Parameters and Guidelines, adopted by the Commission on State Mandates, establishes the state mandate and defines criteria for reimbursement. In compliance with *Government Code* Section 17558, the SCO issues claiming instructions for each mandate requiring state reimbursement to assist counties in claiming reimbursable costs.

Objective, Scope, and Methodology

The objective of the audit was to determine whether costs claimed were increased costs incurred as a result of the legislatively mandated Handicapped and Disabled Students Program (Chapter 1747, Statutes of 1984, and Chapter 1747, Statutes of 1985) for the period of July 1, 1997, through June 30, 1999.

The auditors performed the following procedures:

- Reviewed the costs claimed to determine if they were increased costs resulting from the mandated program;
- Traced the costs claimed to the supporting documentation to determine whether the costs were properly supported;
- Confirmed that the costs claimed were not funded by another source; and
- Reviewed the costs claimed to determine that the costs were not unreasonable and/or excessive.

The SCO conducted the audit in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. The SCO did not audit the county's financial statements. The scope was limited to planning and performing audit procedures necessary to obtain reasonable assurance concerning the allowability of expenditures claimed for reimbursement. Accordingly, transactions were examined, on a test basis, to determine whether the amounts claimed for reimbursement were supported.

Review of the county's management controls was limited to gaining an understanding of the transaction flow and claim preparation process as necessary to develop appropriate auditing procedures.

Conclusion

The SCO audit disclosed instances of noncompliance with the requirements outlined above. These instances are described in the Findings and Recommendations section of this report and in the accompanying Summary of Program Costs (Schedule 1).

For the two-year audit period, Orange County claimed $22,506,432 for costs of the legislatively mandated Handicapped and Disabled Students Program. The audit disclosed that $20,715,374 is allowable and $1,791,058 is unallowable.

For fiscal year (FY) 1997-98, the county was paid $10,585,561 by the State. The audit disclosed that $9,789,068 is allowable. The amount paid in excess of allowable costs claimed, totaling $796,493, should be returned to the State.

For FY 1998-99, the county was paid $11,920,871 by the State. The audit disclosed that $10,926,306 is allowable. The amount paid in excess of allowable costs claimed, totaling $994,565, should be returned to the State.

Views of Responsible Officials

The SCO issued a draft audit report on June 28, 2002. David E. Sundstrom, Auditor-Controller, responded by letter dated September 25, 2002, disagreeing with all findings in the draft report. The county's response is included as an attachment to this audit report.

The draft report included audit adjustments totaling $12,374,953. Audit adjustments in this final report have been reduced by $10,583,895, from $12,374,953 to $1,791,058.

Finding 2 of the draft report disclosed that $119,749 was unallowable because the county claimed various mental health services at rates that exceeded the statewide maximum allowance. Based on previous Commission on State Mandates rulings, the SCO determined that actual county costs incurred in excess of California Department of Mental Health statewide maximum rates are allowable. Consequently, the finding has been eliminated from the final report, and Findings 3 through 5 of the draft report have been renumbered as Findings 2 through 4.

The audit adjustment in Finding 4 of this final report has been revised because of the elimination of Finding 2 of the draft report and legislation occurring after the issuance of the draft report that changed the regulatory criteria (discussed in the Findings and Recommendations section). Consequently, rather than understating realignment funding by $10,445,864, the county overstated realignment funding by $76,257, a difference of $10,522,121.

The remaining findings continue to be valid.

Restricted Use

This report is solely for the information and use of Orange County and the SCO; it is not intended to be and should not be used by anyone other than these specified parties. This restriction is not intended to limit distribution of this report, which is a matter of public record.

WALTER BARNES
Chief Deputy State Controller, Finance

Findings and Recommendations

FINDING 1—Ineligible costs claimed

The county claimed various ineligible case management and treatment costs.

The county claimed case management costs for clients placed in out-of-state residential facilities. These costs are not reimbursable under the Handicapped and Disabled Students Program, but rather under the Seriously Emotionally Disturbed Pupils: Out-of-State Mental Health Services Program.

The county also claimed treatment costs for medication support and crisis intervention, which are not reimbursable under program guidelines.

Parameters and Guidelines allows for reimbursement of increased costs incurred for the specific program filed. *Parameters and Guidelines* specifies that the following treatment services are reimbursable: individual therapy; collateral therapy and contacts; group therapy; day treatment; and the mental health portion of residential treatment in excess of the California Department of Social Services' payments for residential placement.

As a result, ineligible treatment and case management costs claimed are unallowable as follows:

	Audit Adjustment		
	FY 1997-98	FY 1998-99	Totals
Case management costs	$ (54,429)	$ (62,869)	$ (117,298)
Treatment costs	(915,082)	(1,023,438)	(1,938,520)
Totals	$ (969,511)	$(1,086,307)	$(2,055,818)

Recommendation

The county should establish procedures to ensure that costs claimed are eligible increased costs incurred as a result of the mandate.

Auditee's Response

> The County does not concur. We have established procedures to ensure that costs claimed are eligible increased costs incurred as a result of the mandate, and we have been following those procedures since we started submitting claims for the *Handicapped and Disabled Students Program*. In the narrative below we have responded to the auditor's findings on (a) case management costs for clients placed in out-of-state residential facilities, (b) treatment costs for medication support, and (c) treatment costs for crisis intervention separately.
>
> a) **Case Management costs for clients placed in out-of-state residential facilities.**
>
> The County concurs that these costs are reimbursable under the *Seriously Emotionally Disturbed* (SED) *Pupils: Out-of-State Mental*

Health Services Program, and we have subsequently claimed these costs in the *SED* claim for Fiscal Years 1997-98, 1998-99, 1999-2000, and 2000-01.

However, at the time we filed the *Handicapped and Disabled Students Program* claims for Fiscal Years 1997-98 and 1998-99, which are the years being audited, the *SED Program* had not been identified as a mandated program, and the County believed that these costs were eligible to be claimed as part of the *Handicapped and Disabled Students Program* mandate. Claiming instructions for the *SED Program* were not issued until January 2001.

b) **Treatment Costs for Medication Support.**

The County does not concur that these are ineligible costs.

The *Parameters and Guidelines*, Summary of Mandates, references California Code of Regulations, Division 9, Sections 60000-60200, Title 2, as well as Division 7, Title 1 of the Government Code commencing with Section 7570. The *Parameters and Guidelines* specifically cites Government Code sections 7571 and 7576 and their implementing regulations as governance. The "implementing regulations" for the provision of Chapter 25.6 of the Government Code are found in the California Code of Regulations, Title 2, Division 9, the Joint Regulations for Handicapped Children.

Section 7576 (amended in 1996) of the Government Code identifies the Department of Mental Health's responsibility for the provision of Mental Health services and states, in part, that the Department of Mental Health "shall be responsible for the provision of mental health services as defined in regulations by the State Department of Mental Health, developed in connection with the State Department of Education, when required in the pupil's individualized education plan."

Additionally, the *Parameters and Guidelines* references Section 5651 of the Welfare and Institutions code which assures, in part, that "the county shall provide the mental health services required by Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code and will comply with all requirement of that chapter."

The California Code of Regulations in Section 60020(i) defines Mental Health services as such: "Mental Health services" means mental health assessments and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code: psychotherapy as defined in Section 2903 of the Business and Professions Code; provided to the pupil individually or in a group, collateral services, ***medication monitoring***, intensive day treatment, day rehabilitation, and case management. "Medication monitoring" is clearly defined in 60020(f) as including all medication support services including prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. The cost of the medications is not a covered service and has not been billed in the SB90 claiming process.

By citing the above code sections that mandate medication monitoring as a service provided under Chapter 26.5, the *Parameters and Guidelines* includes medication monitoring by implication and reference. That this service was not specifically listed in the guidelines was clearly an oversight and indicates that the *Parameters and Guidelines* need to be amended accordingly.

c) **Treatment Costs for Crisis Intervention**

The County does not concur that these are ineligible costs.

It was the intent of AB3632 and later amendments not to include mental health services designed to respond to "psychiatric emergencies or other situations requiring an immediate response" (Article 2, section 60040(e)). This language was related primarily to inpatient hospitalization. The services currently in dispute were not provided as psychiatric emergency services leading to hospitalization or other emergency care, but rather were provided in the normal course of mental health treatment. These services were provided as defined in the California Code of Regulations, Title 9, Section 543, and designed to alleviate problems which, if untreated, presented imminent threat to the pupil.

SCO's Comments

The finding and recommendation for ineligible case management costs for clients placed in out-of-state residential facilities, and treatment costs for medication support and crisis intervention, remain unchanged.

Case management costs incurred for handicapped and disabled students placed in out-of-state schools are an ineligible cost for the Handicapped and Disabled Students Program but are eligible under the Seriously Emotionally Disturbed Pupils: Out-of State Mental Health Services Program. *Parameters and Guidelines* for this program, adopted October 26, 2000, allows claimants to claim costs commencing on January 1, 1997.

Parameters and Guidelines, Section V(B)2, specifies the following treatment services, when required by a child's individualized education program (IEP), are reimbursable: individual therapy; collateral therapy and contacts; group therapy; day treatment; and the mental health portion of residential treatment in excess of the California Department of Social Services' payments for residential placement. Each treatment service above is defined under Title 9, Section 543 of the *California Administrative Code*. Since medication monitoring and crisis intervention were both defined in regulation at the time *Parameters and Guidelines* was adopted and were not included as reimbursable costs, the only reasonable conclusion is that they were intentionally excluded and, therefore, not reimbursable.

FINDING 2— SEP funds inequitably distributed

The county deducted Special Education Pupil (SEP) categorical funds, also known as AB 3632 funds, received from the State on its claim. However, the offsets were made to treatment costs rather than in direct proportion to allowable assessment/case management and treatment costs.

As a result, SEP funds have been reallocated as follows:

	Audit Adjustment		
	FY 1997-98	FY 1998-99	Totals
Assessment costs	$ (270,394)	$ (255,773)	$ (526,167)
Treatment costs	270,394	255,773	526,167
Difference	$ —	$ —	$ —

Recommendation

The county should ensure that SEP funds are properly allocated to assessment and treatment costs.

Auditee's Response

> The County does not concur. Even though this is merely a redistribution, with no dollar difference between the amounts claimed and the amounts allowed, the County does not concur with the SCO auditor's reason for this redistribution. The auditor states that the redistribution was necessary because the net assessment/case management costs are fully reimbursable under this mandate, while net treatment costs are reimbursable at a rate of only 10%. The County believes that **both** assessment/case management and treatment costs are fully reimbursable. As stated in the response to Finding 5 below, this issue is being clarified in budget trailer bill legislation (AB 2781).

SCO's Comments

The narrative portion of this finding has been edited as a result of a legislative change in allowable treatment costs (see Finding 4). However, the fiscal effect of the finding and recommendation remains unchanged.

FINDING 3— Medi-Cal revenue offsets overstated

The county properly offset its claimed costs by the amount of Medi-Cal funding received that was applicable to the mental health treatment services provided. However, since the SCO auditor reduced the amount of allowable treatment costs in Finding 1 above, the county's Medi-Cal revenue offsets are overstated as follows:

	Audit Adjustment		
	FY 1997-98	FY 1998-99	Totals
Treatment costs:			
Medi-Cal offsets claimed	$ 768,403	$ 631,404	$ 1,399,807
Medi-Cal offsets allowed	(671,642)	(539,662)	(1,211,304)
Difference	$ 96,761	$ 91,742	$ 188,503

Recommendation

No recommendation is necessary because the county properly offset Medi-Cal funding received against claimed costs.

Auditee's Response

> The auditor credited back the federal share of Medi-Cal revenue that was received for services found to be ineligible for compensation under this claim. This credit back to the County would be adjusted if any disallowed services are found to be eligible.

SCO's Comments

No adjustment to Medi-Cal revenue offsets is required because no revision has been made to Finding 1.

FINDING 4— Fiscal effect of Assembly Bill 2781 on net treatment costs

For FY 1997-98, the county claimed net mental health treatment costs at a level greater than 10% of allowable net treatment costs reimbursable under this program. A portion of the non-reimbursable costs was funded with realignment (non-categorical) funds. For FY 1998-99, the county claimed 100% of net mental health treatment costs incurred rather than 10% of treatment costs.

Parameters and Guidelines specifies that 10% of mental health treatment costs covered by the State's Short-Doyle Act are reimbursable. Therefore, the SCO auditor computed the required offset to claimed costs as follows:

	Audit Adjustment		
	FY 1997-98	FY 1998-99	Totals
Net treatment costs claimed	$ 6,613,403	$ 7,239,637	$ 13,853,040
Less treatment costs adjusted in Findings 1 through 4 above	(547,927)	(675,923)	(1,223,850)
Allowable net treatment costs	6,065,476	6,563,714	12,629,190
Less reimbursable costs (10%)	(606,548)	(656,371)	(1,262,919)
Non-reimbursable costs (90%)	5,458,928	5,907,343	11,366,271
Non-reimbursable costs claimed	(920,407)	—	(920,407)
(Understated) funding of non-reimbursable costs [1]	$ (4,538,521)	$(5,907,343)	$(10,445,864)

[1] The audit adjustment for understated funding of non-reimbursable costs was increased by $57,975, from $10,387,889 ($4,480,546 for FY 1997-98 and $5,907,343 for FY 1998-99) to $10,445,864 ($4,538,521 for FY 1997-98 and $5,907,343 for FY 1998-99) because of the elimination of the finding relating to claimed unit rates exceeding the maximum rates allowable.

On September 30, 2002, (subsequent to the issuance of the draft report) AB 2781 (Chapter 1167, Statutes of 2002) changed the *Parameters and Guidelines* regulatory criteria. The legislation states that the percentage of treatment costs claimed by counties for FY 2000-01 and prior fiscal years is not subject to dispute by the SCO. Consequently, the SCO applied the percentage of net treatment costs claimed to allowable net

treatment costs. As a result, rather than understating realignment funding by $10,445,864, the county overstated realignment funding by $76,257, a difference of $10,522,121, as follows:

	Audit Adjustment		
	FY 1997-98	FY 1998-99	Total
Calculation to determine allowable net treatment costs:			
Net treatment costs claimed	$ 6,613,403	$ 7,239,637	$ 13,853,040
Less realignment funding claimed	(920,407)	—	(920,407)
Adjusted net treatment costs claimed	$ 5,692,996	$ 7,239,637	$ 12,932,633
Percentage of adjusted net treatment costs claimed	86.08%	100%	
Calculation to determine overstated realignment funding claimed:			
Allowable net treatment costs per audit	$ 6,065,476	$ 6,563,714	$ 12,629,190
Percentage of treatment costs claimed	86.08%	100%	
Reimbursable treatment costs	$ 5,221,326	$ 6,563,714	$ 11,785,040
Less allowable net treatment costs per audit	(6,065,476)	(6,563,714)	(12,629,190)
Realignment funding per audit	$ (844,150)	—	$ (844,150)
Less realignment funding claimed	(920,407)	—	(920,407)
Overstated realignment funding claimed	$ 76,257	$ —	$ 76,257

Recommendation

The county should ensure that only reimbursable treatment costs are claimed in accordance with program guidelines.

Auditee's Response

> The SCO auditor allowed only 10% of treatment costs related to this program, while the County claimed these costs at 100%. Since this issue is being clarified in budget trailer legislation (AB 2781), the County will reserve comment and discussion on this matter pending the outcome of this legislative effort.

SCO's Comments

The above finding has been adjusted to reflect the fiscal effect of AB 2781. AB 2781 reduced realignment funding and, therefore, increased net reimbursable costs by $10,522,121 ($4,614,778 for FY 1998-99 and $5,907,343 for FY 1999-2000).

Schedule 1— Summary of Program Costs July 1, 1997, through June 30, 1999

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustments	Reference [1]
July 1, 1997, through June 30, 1998				
Assessment/case management costs	$ 4,043,451	$ 3,989,022	$ (54,429)	Finding 1
Administrative costs	1,112,862	1,112,862	—	
Offsetting revenues:				
State categorical funds	—	(270,394)	(270,394)	Finding 2
Short-Doyle/Medi-Cal funds	(263,748)	(263,748)	—	
Net assessment/case management costs	4,892,565	4,567,742	(324,823)	
Treatment costs	6,763,081	5,847,999	(915,082)	Finding 1
Administrative costs	1,410,275	1,410,275	—	
Offsetting revenues:				
State categorical funds	(791,550)	(521,156)	270,394	Finding 2
Short-Doyle/Medi-Cal funds	(768,403)	(671,642)	96,761	Finding 3
Net treatment costs	6,613,403	6,065,476	(547,927)	
Realignment funding adjustment	(920,407)	(844,150)	76,257	Finding 4
Net treatment costs after funding adjustment	5,692,996	5,221,326	(471,670)	
Total costs	$10,585,561	9,789,068	$ (796,493)	
Amount paid by the State		(10,585,561)		
Amount paid in excess of allowable costs claimed		$ 796,493		
July 1, 1998, through June 30, 1999				
Assessment/case management costs	$ 3,682,941	$ 3,620,072	$ (62,869)	Finding 1
Administrative costs	1,315,956	1,315,956	—	
Offsetting revenues:				
State categorical funds	—	(255,773)	(255,773)	Finding 2
Short-Doyle/Medi-Cal funds	(317,663)	(317,663)	—	
Net assessment/case management costs	4,681,234	4,362,592	(318,642)	
Treatment costs	6,778,968	5,755,530	(1,023,438)	Finding 1
Administrative costs	1,883,623	1,883,623	—	
Offsetting revenues:				
State categorical funds	(791,550)	(535,777)	255,773	Finding 2
Short-Doyle/Medi-Cal funds	(631,404)	(539,662)	91,742	Finding 3
Net treatment costs	7,239,637	6,563,714	(675,923)	
Total costs	$11,920,871	10,926,306	$ (994,565)	
Amount paid by the State		(11,920,871)		
Amount paid in excess of allowable costs claimed		$ 994,565		

Schedule 1 (continued)

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustments	Reference [1]
Summary: July 1, 1997, through June 30, 1999				
Assessment/case management costs	$ 7,726,392	$ 7,609,094	$ (117,298)	Finding 1
Administrative costs	2,428,818	2,428,818	—	
Offsetting revenues:				
State categorical funds	—	(526,167)	(526,167)	Finding 2
Short-Doyle/Medi-Cal funds	(581,411)	(581,411)	—	
Net assessment/case management costs	9,573,799	8,930,334	(643,465)	
Treatment costs	13,542,049	11,603,529	(1,938,520)	Finding 1
Administrative costs	3,293,898	3,293,898	—	
Offsetting revenues:				
State categorical funds	(1,583,100)	(1,056,933)	526,167	Finding 2
Short-Doyle/Medi-Cal funds	(1,399,807)	(1,211,304)	188,503	Finding 3
Net treatment costs	13,853,040	12,629,190	(1,223,850)	
Realignment funding adjustment	(920,407)	(844,150)	76,257	Finding 4
Net treatment costs after funding adjustment	12,932,633	11,785,050	(1,147,593)	
Total costs	$22,506,432	20,715,374	$(1,791,058)	
Amount paid by the State		(22,506,432)		
Amount paid in excess of allowable costs claimed		$ 1,791,058		

[1] See Schedule 2

Schedule 2— Summary of Audit Adjustments July 1, 1997, through June 30, 1999

	Audit Adjustments[1]				
	Finding 1	Finding 2	Finding 3	Finding 4	Total
July 1, 1997, through June 30, 1998					
Assessment/case management costs	$ (54,429)	$ —	$ —	$ —	$ (54,429)
Offsetting revenues:					
State categorical funds	—	(270,394)	—	—	(270,394)
Net assessment/case management costs	(54,429)	(270,394)	—	—	(324,823)
Treatment costs	(915,082)	—	—	—	(915,082)
Offsetting revenues:					
State categorical funds	—	270,394	—	—	270,394
Short-Doyle/Medi-Cal funds	—	—	96,761	—	96,761
Net treatment costs	(915,082)	270,394	96,761	—	(547,927)
Realignment funding adjustment	—	—	—	76,257	76,257
Net treatment costs after funding adjustment	(915,082)	270,394	96,761	76,257	(471,670)
Total adjustment for FY 1997-98	(969,511)	—	96,761	76,257	(796,493)
July 1, 1998, through June 30, 1999					
Assessment/case management costs	(62,869)	—	—	—	(62,869)
Offsetting revenues:					
State categorical funds	—	(255,773)	—	—	(255,773)
Net assessment/case management costs	(62,869)	(255,773)	—	—	(318,642)
Treatment costs	(1,023,438)	—	—	—	(1,023,438)
Offsetting revenues:					
State categorical funds	—	255,773	—	—	255,773
Short-Doyle/Medi-Cal funds	—	—	91,742	—	91,742
Net treatment costs	(1,023,438)	255,773	91,742	—	(675,923)
Total adjustment for FY 1998-99	(1,086,307)	—	91,742	—	(994,565)
Totals	$ (2,055,818)	$ —	$ 188,503	$ 76,257	$ (1,791,058)

[1] See Findings and Recommendations section.

Attachment—
Auditee's Response to Draft Audit Report

AUDITOR-CONTROLLER
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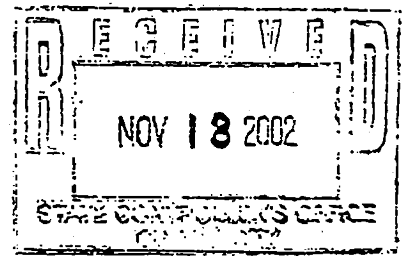
September 25, 2002



State Controller's Office
Division of Audits
P.O. Box 942850
Sacramento, CA 94250-5874

Attn: Jim L. Spano, Chief
Compliance Audits Bureau

We have reviewed the draft report prepared by the State Controller's Office covering their audit of the claims filed by our county for the costs of the legislatively mandated *Handicapped and Disabled Students Program* (Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985), for the period of July 1, 1997 through June 30, 1999.

The County does not concur with the recommendations made in this draft report. However, regarding the recommendation dealing with case management costs for clients placed in out-of-state residential facilities, the County has claimed these expenditures under a separate, newly-identified mandated costs claim. Our responses to the auditor's findings are attached.

Please contact Shaun Skelly at (714) 834-5521 if you have any questions concerning our responses.

David E. Sundstrom
Auditor-Controller

DES:as

Attachment
cc: Doug Barton, Health Care Agency, Behavioral Health Services
Alice Manning, Health Care Agency, Financial & Administrative Services
Shaun Skelly, Auditor-Controller, Agency Accounting
Alice Sworder, Health Care Agency Accounting

RESPONSES TO ORANGE COUNTY AUDIT REPORT HANDICAPPED AND DISABLED STUDENTS PROGRAM

Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985
July 1, 1997 through June 30, 1999

1. FINDING 1 – Ineligible costs claimed

Recommendation: The county should establish procedures to ensure that costs claimed are eligible increased costs incurred as a result of the mandate.

Response:
The County does not concur. We have established procedures to ensure that costs claimed are eligible increased costs incurred as a r--sult of the mandate, and we have been following those procedures since we started submitting claims for the *Handicapped and Disabled Students Program*. In the narrative below we have responded to the auditor's findings on (a) case management costs for clients placed in out-of-state residential facilities, (b) treatment costs for medication support, and (c) treatment costs for crisis intervention separately.

a) **Case Management costs for clients placed in out-of-state residential facilities.**
The County concurs that these costs are reimbursable under the *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services Program*, and we have subsequently claimed these costs in the *SED* claim for Fiscal Years 1997-98, 1998-99, 1999-2000, and 2000-01.

However, at the time we filed the *Handicapped and Disabled Students Program* claims for Fiscal Years 1997-98 and 1998-99, which are the years being audited, the *SED Program* had not been identified as a mandated program, and the County believed that these costs were eligible to be claimed as part of the *Handicapped & Disabled Students Program* mandate. Claiming instructions for the *SED Program* were not issued until January 2001.

b) **Treatment Costs for Medication Support.**
The County does not concur that these are ineligible costs.

The *Parameters and Guidelines*, Summary of Mandates, references California Code of Regulations, Division 9, Sections 60000-60200, Title 2, as well as Division 7, Title 1 of the Government Code commencing with Section 7570. The *Parameters and Guidelines* specifically cites Government Code sections 7571 and 7576 and their implementing regulations as governance. The "implementing regulations" for the provision of Chapter 25.6 of the Government Code are found in the California Code of Regulations, Title 2, Division 9, the Joint Regulations for Handicapped Children.

Section 7576 (amended in 1996) of the Government Code identifies the Department of Mental Health's responsibility for the provision of Mental Health services and states, in part, that the Department of Mental Health "shall be responsible for the provision of mental health services as defined in regulations by the State Department of Mental Health, developed in connection with the State Department of Education, when required in the pupil's individualized education plan."

Additionally, the *Parameters and Guidelines* references Section 5651 of the Welfare and Institutions code which assures, in part, that "the county shall provide the mental health services required by Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code and will comply with all requirement of that chapter."

The California Code of Regulations in Section 60020(i) defines Mental Health services as such: "Mental Health services" means mental health assessments and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code; psychotherapy as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, ***medication monitoring***, intensive day treatment, day rehabilitation, and case management. "Medication monitoring" is clearly defined in 60020(f) as including all medication support services including prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. The cost of the medications is not a covered service and has not been billed in the SB90 claiming process.

By citing the above code sections that mandate medication monitoring as a service provided under Chapter 26.5, the *Parameters and Guidelines* includes medication monitoring by implication and reference. That this service was not specifically listed in the guidelines was clearly an oversight and indicates that the *Parameters and Guidelines* need to be amended accordingly.

c) **Treatment Costs for Crisis Intervention**
The County does not concur that these are ineligible costs.

It was the intent of AB3632 and later amendments not to include mental health services designed to respond to "psychiatric emergencies or other situations requiring an immediate response" (Article 2, section 60040(e)). This language was related primarily to inpatient hospitalization. The services currently in dispute were not provided as psychiatric emergency services leading to hospitalization or other emergency care, but rather were provided in the normal course of mental health treatment. These services were provided as defined in the California Code of Regulations, Title 9, Section 543, and designed to alleviate problems which, if untreated, presented imminent threat to the pupil.

2. FINDING 2 – Claimed unit rates exceeded the maximum rates allowable.

Recommendation: The county should ensure that costs claimed are within the maximum rates set by the California Department of Mental Health.

Response: The County does not concur. We believe this finding by the State Controller is misstated in three respects. The first relates to the County's right to reimbursement of the costs of performing the mandated activity. The second relates to an existing interpretation by the Commission on State mandates relating to capitated rates relating to SB 90 programs. The third relates to the State Controller's misrepresentation of the *Parameters and Guidelines* for this program.

1. Article XIIIB, Section 6 of the State Constitution allows for the reimbursement of the costs of state mandates passed down to local agencies:

CALIFORNIA CONSTITUTION
ARTICLE 13B: GOVERNMENT SPENDING LIMITATION

SEC. 6. Whenever the Legislature or any state agency mandates a new program or higher level of service on any local government, the State shall provide a subvention of funds to reimburse such local government for the costs of such program or increased level of service...

2. The Commission on State Mandates has contemplated the issue of capitated rates vs. full-cost rates in their revised parameters and guidelines for the program known as *Prisoner Parental Rights* (Chapter 1376, Statutes of 1976, Welfare and Institutions Code, Sections 366.26 and 300 c, e, f, I and j). The Commission ruled that the mandated costs associated with Article XIIIB, Section 6 of the State Constitution could not be capitated at a statewide level. They ruled that the State was required to reimburse local agencies for the full cost rate, and required local governments to provide additional documentation if they used a rate higher than the average daily jail rate. This situation is identical. The Department of Justice, just like the California Department of Mental Health, annually establishes statewide reimbursement rates, otherwise referred to as statewide maximum allowances (SMAs). These SMAs or capitated rates are applicable to many purposes, but they are not to be applied to state mandated costs covered under Article XIIIB.

3. In the draft audit findings, the State Controller misrepresents what is stated in the *Parameters and Guidelines* by saying, "Parameters and Guidelines states that reimbursable costs are governed by the Short-Doyle/Medi-Cal Program." The *Parameters and Guidelines* refer to the Short-Doyle/Medi-Cal Program in the following contexts:

- IEP participation is not subject to the Short-Doyle Act (Summary of the Mandate)
- Provisions of WIC Section 5651, Subdivision (g), result in a higher level of service within the county Short-Doyle program (Summary of the Mandate)
- Such mental health services are subject to the current cost sharing formula of the Short-Doyle Act (90-10 cost sharing). (Summary of the Mandate)
- Any mental health treatment required by an IEP is subject to the Short-Doyle cost sharing formula. (Commission on State Mandates' decision)
- Reimbursable activities not subject to the Short-Doyle Act (IEP costs, et al). (Reimbursable Costs)
- The scope of the mandate is 100% reimbursement, except that for individuals billed to Medi-Cal only, the Federal Financing Participation portion (FFP) for these activities should be deducted from the reimbursable activities not subject to the Short-Doyle Act. (Reimbursable Costs)
- Reimbursable activities subject to the Short-Doyle Act, or Mental Health Treatment Services. (Reimbursable Costs)
    - Scope of mandate is 10% reimbursement
    - Provision of mental health services when required by child's IEP are 10% reimbursable: Individual therapy, Collateral therapy and contacts, Group therapy, Day treatment, and Mental Health portion of residential treatment in excess of the Department of Social Services payment for the residential placement.
- Any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments and Medi-Cal payments), which is received from any source, e.g. federal, state, etc.

Those are the sum total of references to the term "Short-Doyle" in the *Parameters and Guidelines* for this program. At no point is it stated or implied that the Short-Doyle program governs the definition of reimbursable costs as the State Controller notes in the audit finding. Therefore, we do not agree with the conclusions reached by the State Controller in Finding 2.

EXHIBIT C

AUDITOR-CONTROLLER
COUNTY OF ORANGE

HALL OF FINANCE AND RECORDS
12 CIVIC CENTER PLAZA, ROOM 202
POST OFFICE BOX 567
SANTA ANA, CALIFORNIA 92702-0567

(714) 834-2450 FAX: (714) 834-2569

www.oc.ca.gov/ac

JOHN H. NAKANE
CHIEF ASSISTANT AUDITOR-CONTROLLER

JAMES M. McCONNELL
ASSISTANT AUDITOR-CONTROLLER
CENTRAL OPERATIONS

SHAUN M. SKELLY
ASSISTANT AUDITOR-CONTROLLER
AGENCY ACCOUNTING

MAHESH N. PATEL
ASSISTANT AUDITOR-CONTROLLER
INFORMATION TECHNOLOGY

DAVID E. SUNDSTROM, CPA
AUDITOR-CONTROLLER

May 22, 2003

Steve Westly
California State Controller
Division of Accounting and Reporting
P. O. Box 942850
Sacramento, CA 94250

Attn: Ginny Brummels

Re: Handicapped and Disabled Students Claim, Chapter 1747/84
Fiscal Years 1997/98 and 1998/99

This is in response to your letters of April 28, 2003, instructing our office to remit a payment for $796,493 for amounts owed to the State for our county's Fiscal Year 1997/98 claim for the *Handicapped and Disabled Students* mandated cost program, and $994,565 for the Fiscal Year 1998/99 claim. As stated in our letter of February 24, 2003, the County does not concur with the State Controller's audit finding that these costs, which represent medication monitoring and crisis intervention services, are ineligible for reimbursement. Therefore, we will not be remitting payment for these costs, and we do not agree that the State Controller should offset these amounts from the next payments due to our county for State mandated cost programs.

We had previously requested a review of all disputed issues named in your audit report for this program, and we supplied documentation supporting our responses to the audit. Our request for a review was denied. It is therefore our county's intention to file an Incorrect Reduction Claim with the Commission on State Mandates.

Please contact Sandra Fair, Chief of Behavioral Health Operations for the Health Care Agency for the County of Orange, at (714) 834-6032, if you wish further information on the health services being disallowed in your audit. Contact Shaun Skelly of my office at (714) 834-5521 if you have any questions concerning this correspondence.

David E. Sundstrom
Auditor-Controller

DES:as

cc: Jim L. Spano, State Controller's Office, Compliance Audit Bureau
Walter Barnes, Chief Deputy State Controller, Finance
Sandra Fair, Health Care Agency, Behavioral Health Services
Alice Manning, Health Care Agency, Financial & Administrative Services
Shaun Skelly, Auditor-Controller, Agency Accounting
Alice Sworder, Auditor-Controller, Health Care Agency Accounting

9930

STEVE WESTLY
CALIFORNIA STATE CONTROLLER
DIVISION OF ACCOUNTING AND REPORTING

APRIL 28, 2003

AUDITOR-CONTROLLER
COUNTY OF ORANGE
P O BOX 567
SANTA ANA CA 92702

DEAR CLAIMANT:

RE: HANDI & DISABLE STU CH 1747/84

WE HAVE REVIEWED YOUR 1998/1999 FISCAL YEAR REIMBURSEMENT CLAIM FOR THE MANDATED COST PROGRAM REFERENCED ABOVE. THE RESULTS OF OUR REVIEW ARE AS FOLLOWS:

AMOUNT CLAIMED	11,920,871.00
LESS: TOTAL ADJUSTMENTS (DETAIL ON PAGE 2)	- 994,565.00
CLAIM AMOUNT APPROVED	10,926,306.00
LESS: TOTAL PRIOR PAYMENTS (DETAIL ON PAGE 2)	11,920,871.00
AMOUNT DUE STATE	$ 994,565.00

PLEASE REMIT A WARRANT IN THE AMOUNT OF $ 994,565.00 WITHIN 30 DAYS FROM THE DATE OF THIS LETTER, PAYABLE TO THE STATE CONTROLLER'S OFFICE, DIVISION OF ACCOUNTING AND REPORTING, P.O. BOX 942850, SACRAMENTO, CA 94250-5875 WITH A COPY OF THIS LETTER. FAILURE TO REMIT THE AMOUNT DUE WILL RESULT IN OUR OFFICE PROCEEDING TO OFFSET THE AMOUNT FROM THE NEXT PAYMENTS DUE TO YOUR AGENCY FOR STATE MANDATED COST PROGRAMS.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT FRAN STUART AT (916) 323-0766 OR IN WRITING AT THE ABOVE ADDRESS.

SINCERELY,

Ginny Brummels

GINNY BRUMMELS
MANAGER

LOCAL REIMBURSEMENT SECTION
P.O. BOX 942850 SACRAMENTO, CA 94250-5875

AUDITOR-CONTROLLER
MAY 0 2 2003

ADJUSTMENT TO CLAIM:		
FIELD AUDIT FINDINGS	- 994,565.00	
LESS: TOTAL ADJUSTMENTS		- 994,565.00
PRIOR PAYMENTS:		
SCHEDULE NO. MA01326A PAID 09-25-2000	0.00	
SCHEDULE NO. MA91376A PAID 03-20-2000	1,920,871.00	
SCHEDULE NO. MA81002E PAID 03-03-1999	10,000,000.00	
LESS: TOTAL PRIOR PAYMENTS		11,920,871.00

STEVE WESTLY
California State Controller
Division of Accounting and Reporting

April 28, 2003

The Honorable David E. Sundstrom
Auditor-Controller, Orange County
12 Civic Center Plaza
Santa Ana, CA 92701

Dear Claimant:

Re: HANDICAPPED & DISABLED STUDENTS CH 1747/84

We have reviewed your 1997/1998 fiscal year reimbursement claim for the mandated cost program referenced above. The results of our review are as follows:

Amount Claimed	$10,585,561.00
Less: Total Adjustments (Detail on Page 2)	-796,493.00
Claim Amount Approved	9,789,068.00
Less: Total Prior Payments (Detail on Page 2)	-10,585,561.00
Amount Due State	$-796,493.00

Please remit a warrant in the amount of $796,493.00 within 30 days from the date of this letter, payable to the State Controller's Office, Division of Accounting and Reporting, P. O. Box 942850, Sacramento, CA 94250-5875 with a copy of this letter. Failure to remit the amount due will result in our office proceeding to offset the amount from the next payments due to your agency for State Mandated Cost Programs. If you have any questions, please contact Fran Stuart at (916) 323-0766 or in writing at the above address.

Sincerely,

Ginny Brummels

Ginny Brummels,
Manager

MAILING ADDRESS P.O. Box 942850, Sacramento, CA 94250
SACRAMENTO 3301 C Street, Suite 500, Sacramento, CA 95816 (916) 445-8717

ADJUSTMENT TO CLAIM

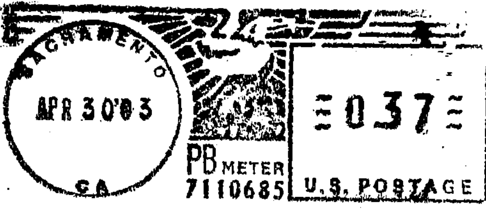
Field Audit Findings	-$796,493.00	
Less: Total Adjustments		-$796,493.00

PRIOR PAYMENTS:

SCHEDULE NO. MA71656E PAID 01/22/1998	$5,213,171.00	
SCHEDULE NO. MA81005A PAID 03/15/1999	$1,698,983.00	
SCHEDULE NO. MA91305A PAID 08/13/1999	$3,662,883.00	
SCHEDULE NO. MA91332A PAID 10/29/1999	$ 10,524.00	
Less: Total Prior Payments		- $10,585,561.00

STEVE WESTLY
CALIFORNIA STATE CONTROLLER

P.O. BOX 942850
SACRAMENTO, CA 94250-0001



MAY 02 2003
AUDITOR-CONTROLLER

92701#4057

EXHIBIT D

COUNTY OF ORANGE
HEALTH CARE AGENCY

FINANCIAL AND ADMINISTRATIVE SERVICES

MICHAEL SCHUMACHER
DIRECTOR

DAVID L. RILEY
CHIEF FINANCIAL OFFICER

MAILING ADDRESS:
515 N. SYCAMORE, ROOM 618
SANTA ANA, CA 92701

TELEPHONE: (714) 834-4422
FAX: (714) 834-5506

December 27, 1999

State Controller's Office
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Subject: FY 1998-99 Handicapped & Disabled Students Claim

Attached to the Handicapped & Disabled Students Claim (SB90) is a draft of Orange County's mental health cost report for FY 98-99. At this time, our cost report is in the process of being finalized. After the completion of our cost report, a copy of this version will be sent to your office.

If you have any questions, please call Sheri Vukelich at (714) 834-7591.

Sincerely,

Eliseo Gillamac, Senior Accountant
Behavioral Health Care Accounting

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SERVICES TO HANDICAPPED STUDENTS

For State Controller Use Only
(19) Program Number 00111
(20) Date File ____/____/____
(21) LRS Input ____/____/____

LABEL HERE

(01) Claimant Identification Number	Reimbursement Claim Date
(02) Mailing Address	(22) HDS-1, (03)(a)
Claimant Name	(23) HDS-1, (03)(b)
County of Location	(24) HDS-1, (03)(c)
Street Address or P.O. Box	(25) HDS-1, (04)(1)(d)
City / State / Zip Code	(26) HDS-1, (04)(2)(d)

Type of Claim	Estimated Claim	Reimbursement Claim		
	(03) Estimated [X]	(09) Reimbursement [ ]	(27) HDS-1, (04)(3)(d)	
	(04) Combined [ ]	(10) Combined [ ]	(28) HDS-1, (04)(4)(d)	
	(05) Amended [ ]	(11) Amended [X]	(29) HDS-1, (04)(5)(d)	
			(30) HDS-1, (06)	
Fiscal Year of Cost	(06) 19 99 /2000	(12) 19 98 /19 99	(31) HDS-3, (05)	317,663
Total Claimed Amount	(07) 10,000,000	(13) 11,920,871	(32) HDS-3, (06)	0
Less: 10% Late Penalty, not to exceed $1,000		(14)	(33) HDS-3, (07)	0
Less: Estimated Claim Payment Received		(15) 10,000,000	(34)	
Net Claimed Amount		(16) 1,920,871	(35)	
Due From State	(08) 10,000,000	(17) 1,920,871	(36)	
Due to State		(18)	(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 set forth on the attached statements.

Signature of Authorized Representative: [signature]
Date: 12/27/99

Eliseo Gillamac — Type or Print Name
Senior Accountant/Auditor — Title

(39) Name of Contact Person for Claim: Sheri Vukelich, Accountant/Auditor
Telephone Number: (714) 834-7591 Ext. ______

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SERVICES TO HANDICAPPED STUDENTS

For State Controller Use Only
(19) Program Number 00111
(20) Date File ____/____/____
(21) LRS Input ____/____/____

L A B E L H E R E

(01) Claimant Identification Number	Reimbursement Claim Date
(02) Mailing Address	(22) HDS-1, (03)(a)
Claimant Name	(23) HDS-1, (03)(b)
County of Location	(24) HDS-1, (03)(c)
Street Address or P.O. Box	(25) HDS-1, (04)(1)(d)
City State Zip Code	(26) HDS-1, (04)(2)(d)

Type of Claim	Estimated Claim	Reimbursement Claim		
	(03) Estimated [X]	(09) Reimbursement [ ]	(27) HDS-1, (04)(3)(d)	
	(04) Combined [ ]	(10) Combined [ ]	(28) HDS-1, (04)(4)(d)	
	(05) Amended [ ]	(11) Amended [X]	(29) HDS-1, (04)(5)(d)	
			(30) HDS-1, (06)	
Fiscal Year of Cost	(06) 19 99 /2000	(12) 19 98 /19 99	(31) HDS-3, (05)	From A2 317,663
Total Claimed Amount	(07) 10,000	(13) From A2 11,920,871	(32) HDS-3, (06)	0
Less: 10% Late Penalty, not to exceed $1,000		(14)	(33) HDS-3, (07)	0
Less: Estimated Claim Payment Received		(15) 10,000,000	(34)	
Net Claimed Amount		(16) 1,920,871	(35)	
Due From State	(08)	(17) 1,920,871	(36)	
Due to State		(18)	(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 set forth on the attached statements.

Signature of Authorized Representative ____________________ Date ____________________

Eliseo Gillamac
Type or Print Name

Senior Accountant/Auditor
Title

(39) Name of Contact Person for Claim
Sheri Vukelich, Accountant/Auditor

Telephone Number
(714) 834-7591 Ext. ________

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
CLAIM SUMMARY

FORM HDS-3

(01) Claimant County of Orange/Health Care Agency	(02) Type of Claims Reimbursement [X] Estimated [ ]	Fiscal Year 1998/1999

		Amount
(03)	**Reimbursable Components**	
	Assessment of Individuals With Exceptional Needs	
	(a) Assessment: Interviews, Review of Records, Observations, Testing, etc. From A3	3,682,941
	(b) Residential Placement: IEP Reviews, Case Management, and Expanded IEP	
	(c) Related Services: Attendance at IEP meetings, Meeting with IEP Members and Parents, and Review of Independent Assessment.	
	(d) Due Process Proceedings	
	(e) Administrative Costs From A5	1,315,956
	Mental Health Treatment	
	(f) Treatment Services: Short-Doyle Program From A4.1	6,778,968
	(g) Administrative Costs From A5.1	1,883,623
(04)	Sub-total for Assessment of Individual with Exceptional Needs [Sum of (03), lines (a) to (e)]	4,998,897
(05)	Less: Amount Received from Short-Doyle / Medi-Cal (FFP only) From G2	317,663
(06)	Less: Amount Received from State Categorical Funding	
(07)	Less: Amount Received from Other (Patient Fees)	
(08)	Total for Assessment of Individual with Exceptional Needs [Line (04) minus the sum of lines (05) to (07)	4,681,234
(09)	Sub-Total for Mental Health Treatment [block (03), lines (f) and (g)]	8,662,591
(10)	Less: Non-Categorical State General / Realignment Funds	
(11)	Less: Amount Received from State Categorical Funds From F1	699,001
(12)	Less: Amount Received from Short-Doyle / Medi-Cal (FFP only) From G3	631,404
(13)	Less: Amount Received from Other (SAMSHA Grant, Patient Fees) From J3	92,549
(14)	Total Mental health Treatment [Line (09) minus the sum of lines (10) to (13)]	7,239,637
(15)	Total Claimed Amount [Sum of line (08) and line (14)]	11,920,871

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1998-99

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

[X] Assessment
[ ] Treatment Services
[ ] Residential Placement
[ ] Other (identify)

(04) Description of Expenses: Complete columns (a) through (f). From B1

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
East County - Santa Ana	3006	15/01	209,491	1.1600	243,010
East County - Santa Ana	3006	15/30	230,945	1.4900	344,108
West County - Westminster	3009	15/01	245,996	1.2700	312,415
West County - Westminster	3009	15/30	205,057	1.6300	334,243
CGC Inc. - Fullerton	3051	15/01	42,164	1.0337	43,585
CGC Inc. - Fullerton	3051	15/30	58,332	1.3310	77,640
South County - Laguna	8002	15/01	509,194	0.6900	351,344
South County - Laguna	8002	15/30	632,923	0.8800	556,972
CGC Inc. - Santa Ana	8034	15/01	63,347	1.0337	65,482
CGC Inc. - Santa Ana	8034	15/30	106,989	1.3310	142,402
Western Youth - Garden Grove	8035	15/01	75,103	1.1496	86,338
Western Youth - Garden Grove	8035	15/30	100,484	1.1496	115,516
Western Youth - Laguna	8056	15/01	64,051	1.1496	73,633
Western Youth - Laguna	8056	15/30	280,123	1.1496	322,029
Western Youth - Anaheim	8061	15/01	6,528	1.1496	7,505
Western Youth - Anaheim	8061	15/30	30,261	1.1496	34,788
North County - Placentia	8067	15/01	170,800	1.0700	182,756
North County - Placentia	8067	15/30	276,638	1.3800	381,760
Latino Psych Center	30AE	15/01	1,203	1.4324	1,723
Latino Psych Center	30AE	15/30	3,097	1.8380	5,692
TOTAL ASSESSMENT			3,308,426		

(05) Total	Subtotal	Page: 1 of 1	3,682,941

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1998-99

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

☐ Assessment ☒ Treatment Services

☐ Residential Placement ☐ Other (identify)

(04) Description of Expenses: Complete columns (a) through (f). From 32

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
East County - Santa Ana	3006	15/10	116,558	1.4900	173,671
East County - Santa Ana	3006	15/40	286,730	1.4900	427,228
East County - Santa Ana	3006	15/50	18,875	1.4900	28,124
East County - Santa Ana	3006	15/60	48,891	2.7800	135,917
East County - Santa Ana	3006	15/70	3,673	2.2400	8,228
West County - Westminster	3009	15/10	123,518	1.6300	201,334
West County - Westminster	3009	15/40	399,514	1.6300	651,208
West County - Westminster	3009	15/50	180	1.6300	293
West County - Westminster	3009	15/60	66,169	3.0200	199,830
West County - Westminster	3009	15/70	8,229	2.4300	19,996
CGC Inc. - Fullerton	3051	15/10	99,891	1.3265	132,505
CGC Inc. - Fullerton	3051	15/40	187,119	1.3310	249,055
CGC Inc. - Fullerton	3051	15/50	87,042	1.3310	115,853
CGC Inc. - Fullerton	3051	15/60	10,280	2.2270	22,894
CGC Inc. - Fullerton	3051	15/70	3,420	2.4683	8,442
Sounty County - Laguna	8002	15/10	565,539	0.8800	497,674
Sounty County - Laguna	8002	15/40	1,021,061	0.8800	898,534
Sounty County - Laguna	8002	15/50	125,679	0.8800	110,598
Sounty County - Laguna	8002	15/60	144,887	1.6400	237,615
Sounty County - Laguna	8002	15/70	10,645	1.3200	14,051
Aspen Health Services	8079	15/10	18	2.7703	50
Aspen Health Services	8079	15/40	203	2.7703	562
Latino Psych Center	30AE	15/10	4,047	1.8380	7,438
Latino Psych Center	30AE	15/40	4,044	1.8380	7,433
Latino Psych Center	30AE	15/50	1,035	1.8380	1,902
Latino Psych Center	30AE	15/60	140	3.4164	478
			3,337,387		

(05) Total Subtotal X Page: 1 of 2 — 4,150,913

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1998-99

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

☐ Assessment
☒ Treatment Services
☐ Residential Placement
☐ Other (identify)

(04) Description of Expenses: Complete columns (a) through (f). From 62

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
CGC Inc. - Santa Ana	8034	15/10	93,534	1.3265	124,073
CGC Inc. - Santa Ana	8034	15/40	171,414	1.3310	228,152
CGC Inc. - Santa Ana	8034	15/50	6,376	1.3310	8,486
CGC Inc. - Santa Ana	8034	15/60	14,169	2.2270	31,554
CGC Inc. - Santa Ana	8034	15/70	2,288	2.4683	5,647
Western Youth - Garden Grove	8035	15/10	194,136	1.1496	223,179
Western Youth - Garden Grove	8035	15/40	380,490	1.1496	437,411
Western Youth - Garden Grove	8035	15/50	6,012	1.1496	6,911
Western Youth - Garden Grove	8035	15/60	30,405	1.1496	34,954
Western Youth - Garden Grove	8035	15/70	2,324	1.1496	2,672
Western Youth - Laguna	8056	15/10	118,215	1.1496	135,900
Western Youth - Laguna	8056	15/40	251,799	1.1496	289,468
Western Youth - Laguna	8056	15/50	78,256	1.1496	89,963
Western Youth - Laguna	8056	15/60	20,194	1.1496	23,215
Western Youth - Laguna	8056	15/70	328	1.1496	377
Western Youth - Anaheim	8090	15/10	3,441	1.1496	3,956
Western Youth - Anaheim	8090	15/40	9,052	1.1496	10,406
Western Youth - Anaheim	8090	15/50	-	1.1496	-
Western Youth - Anaheim	8090	15/60	1,020	1.1496	1,173
Western Youth - Anaheim	8090	15/70	-	1.1496	0
North County - Placentia	8067	15/10	168,506	1.3800	232,538
North County - Placentia	8067	15/40	331,708	1.3800	457,757
North County - Placentia	8067	15/50	2,803	1.3800	3,868
North County - Placentia	8067	15/60	105,198	2.5600	269,307
North County - Placentia	8067	15/70	3,424	2.0700	7,088
Page Total			1,995,092		2,628,055
Grand Total			5,332,479		

(05)	Total X	Subtotal	Page: 2 of 2	6,778,968

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-6

(01) Claimant: County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred: FY 1998-99

(03) Reimbursable Components: Administrative Costs

[X] Assessment of Individuals   [ ] Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).

(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
			Object Accounts			
Administrative Cost (See Attached Schedule)			From [illegible] 1,315,956			
Totals			1,315,956	0	0	0

(05) Total Direct Costs		1,315,956
Indirect Costs		
(06) Indirect Cost Rate	[From ICRP]	0.00%
(07) Total Indirect Costs	[Line (06) x line (04)(d)] or [Line (06) x { (04)(d) + (04)(e) }]	
(08) Total Direct and Indirect Costs	[Line (05) + line (07)]	1,315,956

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-6

(01) Claimant	(02) Fiscal Year Costs Were Incurred
County of Orange Health Care Agency	FY 1998-99

(03) Reimbursable Components: Administrative Costs

[ ] Assessment of Individuals [X] Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).			Object Accounts			
(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Administrative Cost (See Attached Schedule)			From A&C 1,883,623			
Totals			1,883,623	0	0	0
(05) Total Direct Costs						1,883,623
Indirect Costs						
(06) Indirect Cost Rate	[From ICRP]					0.00%
(07) Total Indirect Costs	[Line (06) x line (04)(d)] or [Line (06) x { (04)(d) + (04)(e) }]					
(08) Total Direct and Indirect Costs	[Line (05) + line (07)]					1,883,623

SB 90 Handicapped & Disabled Students Claim
Allocation of Administration applied to claim
FY 98/99

	Administration	% of Admin. Applied to Mode 15	Mode 15 Administration	SEP/AB 3632 % Assmnt	SEP/AB 3632 % Trtmt	SEP/AB 3632 Administration Assmnt	SEP/AB 3632 Administration Trtmt
Non-M/C Administration (1)	8,369,902	92.39%	7,732,952	10.20%	14.60%	788,761	1,129,011
M/C Administration (2)	5,382,812	96.02%	5,168,576	10.20%	14.60%	527,195	754,612
Total	13,752,714		12,901,528			1,315,956	1,883,623

Notes:
Allocation of administration to mode 15 based on total labor charges (salaries and wages).
(1) Non/Medi-Cal administration allocated to all modes of services. (2) Medi-Cal administration allocated to the modes of services which generate Medi-Cal.
(3) Mode 15 administration allocated to AB 3632 program based on units of service.

EXHIBIT E

CLAIM FOR PA[illegible]NT
Pursuant to Government Code Section 17561
SERVICES TO HANDICAPPED STUDENTS

State Controller Use Only	
(19) Program Number 00111	
(20) Date File	___/___/___
(21) LRS Input	___/___/___

LABEL HERE		
(01) Claimant Identification Number		
(02) Mailing Address		
Claimant Name		
County of Location		
Street Address or P.O. Box		
City	State	Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated [X]	(09) Reimbursement [ ]
	(04) Combined [ ]	(10) Combined [ ]
	(05) Amended [ ]	(11) Amended [ ] X
Fiscal Year of Cost	(06) 19 98 /19 99	(12) 19 97 /19 98
Total Claimed Amount	(07) 10,000,000	(13) 10,585,561
Less: 10% Late Penalty, not to exceed $1,000		(14)
Less: Estimated Claim Payment Received		(15) 5,213,171
Net Claimed Amount		(16) 5,372,390
Due From State	(08) 10,000,000	(17) 5,372,390
Due to State		(18)

Reimbursement Claim Date	
(22) HDS-1, (03)(a)	
(23) HDS-1, (03)(b)	
(24) HDS-1, (03)(c)	
(25) HDS-1, (04)(1)(d)	
(26) HDS-1, (04)(2)(d)	
(27) HDS-1, (04)(3)(d)	
(28) HDS-1, (04)(4)(d)	
(29) HDS-1, (04)(5)(d)	
(30) HDS-1, (06)	
(31) HDS-3, (05)	263,748
(32) HDS-3, (06)	0
(33) HDS-3, (07)	0
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 set forth on the attached statements.

Signature of Authorized Representative: Dawn Nelson

Date: 12-24-98

Dawn Nelson
Type or Print Name

Senior Accountant/Auditor
Title

(39) Name of Contact Person for Claim: Sheri Vukelich, Accountant/Auditor

Telephone Number: (714) 834-7591 Ext. ______

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
CLAIM SUMMARY

FORM HDS-3

(01) Claimant County of Orange/Health Care Agency	(02) Type of Claims Reimbursement [X] Estimated [ ]	Fiscal Year 1997/1998

(03) Reimbursable Components	
Assessment of Individuals With Exceptional Needs	
(a) Assessment : Interviews, Review of Records, Observations, Testing, etc.	4,043,451
(b) Residential Placement: IEP Reviews, Case Management, and Expanded IEP	
(c) Related Services: Attendance at IEP meetings, Meeting with IEP Members and Parents, and Review of Independent Assessment.	
(d) Due Process Proceedings	
(e) Administrative Costs	1,112,862
Mental Health Treatment	
(f) Treatment Services: Short-Doyle Program	6,763,081
(g) Administrative Costs	1,410,275
(04) Sub-total for Assessment of Individual with Exceptional Needs [Sum of (03), lines (a) to (e)]	5,156,313
(05) Less: Amount Received from Short-Doyle / Medi-Cal (FFP only)	263,748
(06) Less: Amount Received from State Categorical Funding	
(07) Less: Amount Received from Other (Patient Fees)	
(08) Total for Assessment of Individual with Exceptional Needs [Line (04) minus the sum of lines (05) to (07)	4,892,565
(09) Sub-Total for Mental Health Treatment [block (03), lines (f) and (g)]	8,173,356
(10) Less: Non-Categorical State General / Realignment Funds	920,407
(11) Less: Amount Received from State Categorical Funds	699,001
(12) Less: Amount Received from Short-Doyle / Medi-Cal (FFP only)	768,403
(13) Less: Amount Received from Other (SAMSHA Grant, Patient Fees)	92,549
(14) Total Mental health Treatment [Line (09) minus the sum of lines (10) to (13)]	5,692,996
(15) Total Claimed Amount [Sum of line (08) and line (14)]	10,585,561

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1997-98

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

[X] Assessment
[ ] Treatment Services
[ ] Residential Placement
[ ] Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
East County - Santa Ana	3006	15/01	74,532	1.7100	127,450
East County - Santa Ana	3006	15/30	146,964	2.1900	321,851
West County - Westminster	3009	15/01	121,237	1.3700	166,095
st County - Westminster	3009	15/30	141,760	1.7500	248,080
CGC Inc. - Fullerton	3051	15/01	17,683	1.2909	22,827
CGC Inc. - Fullerton	3051	15/30	112,952	1.5255	172,308
South County - Laguna	8002	15/01	217,148	1.3500	293,150
South County - Laguna	8002	15/30	875,932	1.7300	1,515,362
CGC Inc. - Santa Ana	8034	15/01	28,139	1.2909	36,325
CGC Inc. - Santa Ana	8034	15/30	64,492	1.5255	98,383
Western Youth - Garden Grove	8035	15/01	58,162	1.2081	70,266
Western Youth - Garden Grove	8035	15/30	160,647	1.2031	193,274
Western Youth - Laguna	8056	15/01	44,917	1.2081	54,264
Western Youth - Laguna	8056	15/30	196,658	1.2031	236,599
Western Youth - Westmont	8061	15/01	5,980	1.2081	7,224
Western Youth - Westmont	8061	15/30	11,063	1.2031	13,310
North County - Placentia	8067	15/01	102,282	1.3200	135,012
North County - Placentia	8067	15/30	196,255	1.6900	331,671
TOTAL ASSESSMENT			2,576,803		

(05) Total	Subtotal	Page: 1 of 1	4,043,451

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS COMPONENT / ACTIVITY COST DETAIL	Form HDS-4

(01) Claimant **County of Orange Health Care Agency**	(02) Fiscal Year Costs Were Incurred **FY 1997-98**

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

☐ Assessment ☒ Treatment Services

☐ Residential Placement ☐ Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
East County - Santa Ana	3006	15/10	65,431	2.1900	143,294
East County - Santa Ana	3006	15/40	172,341	2.1900	377,427
East County - Santa Ana	3006	15/50	810	2.1900	1,774
East County - Santa Ana	3006	15/60	25,666	4.0800	104,717
F t County - Santa Ana	3006	15/70	2,711	3.2900	8,919
West County - Westminster	3009	15/10	85,916	1.7500	150,353
West County - Westminster	3009	15/40	352,503	1.7500	616,880
West County - Westminster	3009	15/50	2,346	1.7500	4,106
West County - Westminster	3009	15/60	54,636	3.2500	177,567
West County - Westminster	3009	15/70	5,214	2.6200	13,661
CGC Inc. - Fullerton	3051	15/10	111,088	1.5255	169,465
CGC Inc. - Fullerton	3051	15/40	219,760	1.5255	335,244
CGC Inc. - Fullerton	3051	15/50	54,715	1.5255	83,468
CGC Inc. - Fullerton	3051	15/60	9,275	2.4156	22,405
CGC Inc. - Fullerton	3051	15/70	3,148	2.5859	8,140
Sounty County - Laguna	8002	15/10	436,049	1.7300	754,365
Sounty County - Laguna	8002	15/40	539,572	1.7300	933,460
Sounty County - Laguna	8002	15/50	122,239	1.7300	211,473
Sounty County - Laguna	8002	15/60	90,941	3.2200	292,830
Sounty County - Laguna	8002	15/70	7,671	2.6000	19,945
			2,362,032		
(05) Total Subtotal X Page: 1 of 2					4,429,493

Chapters 1747/84 and 1274/85 New 3/97

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-4

(01) Claimant
County of Orange Health Care Agency

(02) Fiscal Year Costs Were Incurred
FY 1997-98

(03) Reimbursable Components: Check only one box per form to identify the component being claimed

☐ Assessment
☒ Treatment Services
☐ Residential Placement
☐ Other (identify)

(04) Description of Expenses: Complete columns (a) through (f).

(a) Name of Providers	(b) Provider I.D. Numbers	(c) Service Function Codes	(d) Units of Service	(e) Rate per Unit	(f) Total
CGC Inc. - Santa Ana	8034	15/10	107,053	1.5255	163,309
CGC Inc. - Santa Ana	8034	15/40	156,544	1.5255	238,808
CGC Inc. - Santa Ana	8034	15/50	7,614	1.5255	11,615
CGC Inc. - Santa Ana	8034	15/60	15,934	2.4156	38,490
CGC Inc. - Santa Ana	8034	15/70	1,364	2.5859	3,527
Western Youth - Garden Grove	8035	15/10	171,829	1.2031	206,727
Western Youth - Garden Grove	8035	15/40	342,955	1.2031	412,609
Western Youth - Garden Grove	8035	15/50	13,586	1.2031	16,345
Western Youth - Garden Grove	8035	15/60	25,511	1.2242	31,231
Western Youth - Garden Grove	8035	15/70	1,855	1.2232	2,269
Western Youth - Laguna	8056	15/10	97,532	1.2031	117,341
Western Youth - Laguna	8056	15/40	137,339	1.2031	165,233
Western Youth - Laguna	8056	15/50	67,964	1.2031	81,767
Western Youth - Laguna	8056	15/60	7,490	1.2242	9,169
Western Youth - Laguna	8056	15/70	1,917	1.2232	2,345
Western Youth - Westmont	8061	15/10	13,687	1.2031	16,467
Western Youth - Westmont	8061	15/40	26,932	1.2031	32,402
Western Youth - Westmont	8061	15/50	-	1.2031	-
Western Youth - Westmont	8061	15/60	3,061	1.2242	3,747
Western Youth - Westmont	8061	15/70	567	1.2232	694
North County - Placentia	8067	15/10	150,012	1.6900	253,520
North County - Placentia	8067	15/40	207,424	1.6900	350,547
North County - Placentia	8067	15/50	-	-	-
North County - Placentia	8067	15/60	54,264	3.1400	170,389
North County - Placentia	8067	15/70	1,991	2.5300	5,037
Page Total			1,614,425		2,333,588
Grand Total			3,976,457		

(05) Total X	Subtotal	Page: 2 of 2	6,763,081

MANDATED COSTS
SERVICES TO HANDICAPPED STUDENTS
COMPONENT / ACTIVITY COST DETAIL

Form HDS-5

(01) Claimant	(02) Fiscal Year Costs Were Incurred
County of Orange Health Care Agency	FY 1997-98

(03) Reimbursable Components: Due Process Proceedings

(04) Description of Expenses: Complete columns (a) through (g). — **Object Accounts**

(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Totals			0	0	0	0
(05) Total Direct Costs						0
Indirect Costs						
(06) Indirect Cost Rate [From ICRP]						0.00%
(07) Total Indirect Costs [Line (06) x line (05)(d)] or [Line (06) x { (05)(d) + (05)(e) }]						
(08) Total Direct and Indirect Costs [Line (05) + line (07)]						0

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS COMPONENT / ACTIVITY COST DETAIL	Form HDS-6

(01) Claimant	(02) Fiscal Year Costs Were Incurred
County of Orange Health Care Agency	FY 1997-98

(03) Reimbursable Components: Administrative Costs

[X] Assessment of Individuals [ ] Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g). — Object Accounts

(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Administrative Cost (See Attached Schedule)			1,112,862			
Totals			1,112,862	0	0	0

(05) Total Direct Costs		1,112,862
Indirect Costs		
(06) Indirect Cost Rate	[From ICRP]	0.00%
(07) Total Indirect Costs	[Line (06) x line (04)(d)] or [Line (06) x { (04)(d) + (04)(e) }]	
(08) Total Direct and Indirect Costs	[Line (05) + line (07)]	1,112,862

MANDATED COSTS SERVICES TO HANDICAPPED STUDENTS COMPONENT / ACTIVITY COST DETAIL	Form HDS-6

(01) Claimant	(02) Fiscal Year Costs Were Incurred
County of Orange Health Care Agency	**FY 1997-98**

(03) Reimbursable Components: Administrative Costs

[ ] Assessment of Individuals [X] Mental Health Treatment

(04) Description of Expenses: Complete columns (a) through (g).			Object Accounts			
(a) Employee Names, Job Classifications, Functions Performed and Descripton of Expenses	(b) Hourly Rate of Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Office Supplies	(g) Contracted Services
Administrative Cost (See Attached Schedule)			1,410,275			
Totals			1,410,275	0	0	0

(05) Total Direct Costs		1,410,275
Indirect Costs		
(06) Indirect Cost Rate	[From ICRP]	0.00%
(07) Total Indirect Costs	[Line (06) x line (04)(d)] or [Line (06) x { (04)(d) + (04)(e) }]	
(08) Total Direct and Indirect Costs	[Line (05) + line (07)]	1,410,275

Chapters 1747/84 and 1274/85 New 3/97

SB 90 Handicapped & Disabled Students Claim
Allocation of Administration applied to claim
FY 97/98

	From J6 Administration	From A6 % of Admin. Applied to Mode 15	Mode 15 Administration	From A6 SEP/AB 3632 % Assmnt	Trtmt	SEP/AB 3632 Administration Assmnt	Trtmt
Non-M/C Administration (1)	7,976,880	90.67%	7,232,637	9.13%	11.57%	660,340	836,816
M/C Administration (2)	5,190,525	95.49%	4,956,432	9.13%	11.57%	452,522	573,458
Total	13,167,405		12,189,069			1,112,862	1,410,275

Notes:
Allocation of administration to mode 15 based on total labor charges (salaries and wages).
(1) Non/Medi-Cal administration allocated to all modes of services. (2) Medi-Cal administration allocated to the modes of services which generate Medi-Cal.
(3) Mode 15 administration allocated to AB 3632 program based on units of service.

EXHIBIT F

OFFICE OF THE STATE CONTROLLER

STATE MANDATED COSTS CLAIMING INSTRUCTIONS NO. 2006-03

HANDICAPPED AND DISABLED STUDENTS II

February 17, 2006

In accordance with Government Code (GC) section 17561, eligible claimants may submit claims to the State Controller's Office (SCO) for reimbursement of costs incurred for state mandated cost programs. The following are claiming instructions and forms that eligible claimants will use for filing claims for the Handicapped and Disabled Students II (HDS II) program. These claiming instructions are issued subsequent to adoption of the program's Parameters and Guidelines (P's & G's) by the Commission on State Mandates (COSM).

On May 26, 2005, the COSM determined that GC sections 7572.55 and 7576, as added and amended in 1994 and 1996, and the joint regulations adopted by the Departments of Mental Health and Education as emergency regulations in 1998 and final regulations in 1999 (Cal. Code Regs., tit. 2, §§ 60000 et seq.), established costs mandated by the State according to the provisions listed in the P's & G's. For your reference, the P's & G's are included as an integral part of the claiming instructions.

Eligible Claimants

Any city, county, or city and county that incurs increased costs as a result of this mandate, is eligible to claim reimbursement of these costs.

Filing Deadlines

A. Reimbursement Claims

Initial reimbursement claims must be filed within 120 days from the issuance date of claiming instructions. Costs incurred for this program, are eligible for reimbursement for fiscal years 2001-02 to 2004-05. Claims for fiscal years 2001-02 to 2004-05 must be filed with the SCO and be delivered or postmarked on or before **June 19, 2006**. Actual reimbursement claims for fiscal year 2005-06 and estimated claims for fiscal year 2006-07 must be filed on or before **January 16, 2007**.

In order for a claim to be considered properly filed, it must include any specific supporting documentation requested in the instructions. **Claims filed more than one year after the deadline or without the requested supporting documentation will not be accepted.**

B. Late Penalty

1. Initial Claims

AB 3000, enacted into law on September 30, 2002, amended the late penalty assessments on initial claims. Late initial claims submitted **on or after September 30, 2002,** are assessed a late penalty of 10% of the total amount of the initial claims **without limitation.**

2. Annual Reimbursement Claims

All late annual reimbursement claims are assessed a late penalty of 10% subject to the $1,000 limitation regardless of when the claims were filed.

C. Estimated Claims

Unless otherwise specified in the claiming instructions local agencies are not required to provide cost schedules and supporting documents with an estimated claim if the estimated amount does not exceed the previous fiscal year's actual costs by more than 10%. Claimants can simply enter the estimated amount on form FAM-27, line (07).

However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, claimants must complete supplemental claim forms to support their estimated costs as specified for the program to explain the reason for the increased costs. If no explanation supporting the higher estimate is provided with the claim, it will automatically be adjusted to 110% of the previous fiscal year's actual costs. Future estimated claims filed with the SCO must be postmarked by January 15 of the fiscal year in which costs will be incurred. Claims filed timely will be paid before late claims.

Minimum Claim Cost

GC section 17564(a) provides that no claim shall be filed pursuant to Sections 17551 and 17561, unless such claim exceeds one thousand dollars ($1,000).

Reimbursement of Claims

To be eligible for mandated cost reimbursement for any fiscal year, only actual costs may be claimed. Actual costs are those costs actually incurred to implement the mandated activities. Actual costs must be traceable and supported by source documents that show the validity of such costs, when they were incurred, and their relationship to the reimbursable activities. A source document is a document created at or near the same time the actual cost was incurred for the event or activity in question.

Source documents may include, but are not limited to, employee time records or time logs, sign-in sheets, invoices, and receipts. Evidence corroborating the source documents may include, but is not limited to, worksheets, cost allocation reports (system generated), purchase orders, contracts, agendas, training packets, and declarations. Evidence corroborating the source documents may include data relevant to the reimbursable activities otherwise in compliance with local, state, and federal government requirements. However, corroborating documents cannot be substituted for source documents.

Certification of Claim

In accordance with the provisions of GC section 17561, an authorized representative of the claimant shall be required to provide a certification of claim stating: "I certify, (or declare), under penalty of perjury under the laws of the State of California that the foregoing is true and correct," and must further comply with the requirements of the Code of Civil Procedure section 2015.5, for those costs mandated by the State and contained herein.

Audit of Costs

All claims submitted to the SCO are reviewed to determine if costs are related to the mandate, are reasonable and not excessive, and the claim was prepared in accordance with the SCO's claiming instructions and the P's & G's adopted by the COSM. If any adjustments are made to a claim, a "Notice of Claim Adjustment" specifying the claim component adjusted, the amount adjusted, and the reason for the adjustment, will be mailed within 30 days after payment of the claim.

Pursuant to GC section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency pursuant to this chapter is subject to the initiation of an audit by the SCO no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the SCO to initiate an audit shall commence to run from the date of initial payment of the claim.

In any case, an audit shall be completed no later than two years after the date that the audit is commenced. All documents used to support the reimbursable activities must be retained during the period subject to audit. If an audit has been initiated by the SCO during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings. On-site audits will be conducted by the SCO as deemed necessary.

Retention of Claiming Instructions

The claiming instructions and forms in this package should be retained permanently in your Mandated Cost Manual for future reference and use in filing claims. These forms should be duplicated to meet your filing requirements. You will be notified of updated forms or changes to claiming instructions as necessary.

Questions, or requests for hard copies of these instructions, should be faxed to Angie Lowi-Teng at (916) 323-6527 or e-mailed to **LRSDAR@sco.ca.gov.** Or, if you wish, you may call the Local Reimbursements Section at (916) 324-5729.

For your reference, these and future mandated costs claiming instructions and forms can be found on the Internet at **www.sco.ca.gov/ard/local/locreim/index.shtml.**

Address for Filing Claims

Claims should be rounded to the nearest dollar. Submit a signed original and a copy of form FAM-27, Claim for Payment, and all other forms and supporting documents. **(To expedite the payment process, please sign the form in blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)**

Use the following mailing addresses:

If delivered by
U.S. Postal Service:

Office of the State Controller
Attn: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

If delivered by
other delivery services:

Office of the State Controller
Attn: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

Adopted: December 9, 2005

PARAMETERS AND GUIDELINES

Government Code Sections 7572.55 and 7576
Statutes 1994, Chapter 1128, Statutes 1996, Chapter 654

California Code of Regulations, Title 2, Sections 60000 et seq.
(emergency regulations effective July 1, 1998 [Register 98, No. 26],
final regulations effective August 9, 1999 [Register 99, No. 33])

Handicapped and Disabled Students II (02-TC-40/02-TC-49)

Counties of Stanislaus and Los Angeles, Claimants

I. SUMMARY OF THE MANDATE

On May 26, 2005, the Commission on State Mandates (Commission) adopted its Statement of Decision in *Handicapped and Disabled Students II*, finding that Government Code sections 7572.55 and 7576, as added or amended in 1994 and 1996, and the joint regulations adopted by the Departments of Mental Health and Education as emergency regulations in 1998 and final regulations in 1999 (Cal. Code Regs., tit. 2, §§ 60000 et seq.), impose a reimbursable state-mandated program on counties within the meaning of article XIII B, section 6 of the California Constitution and Government Code section 17514.

The Handicapped and Disabled Students program was initially enacted in 1984 and 1985 as the state's response to federal legislation (Individuals with Disabilities Education Act, or IDEA) that guaranteed to disabled pupils, including those with mental health needs, the right to receive a free and appropriate public education. Three other Statements of Decision have been adopted by the Commission on the Handicapped and Disabled Students program. They include *Handicapped and Disabled Students* (CSM 4282), *Reconsideration of Handicapped and Disabled Students* (04-RL-4282-10), and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05).

Eligible claimants are ***not*** entitled to reimbursement under these parameters and guidelines for the activities approved by the Commission in *Handicapped and Disabled Students* (CSM 4282), *Reconsideration of Handicapped and Disabled Students* (04-RL-4282-10), and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05).

These parameters and guidelines address only the amendments to the Handicapped and Disabled Students program. The Commission found, pursuant to the court's ruling in *Hayes v. Commission on State Mandates* (1992) 11 Cal. App.4th 1564, that Government Code sections 7572.55 and 7576, as added or amended in 1994 and 1996, and the joint regulations adopted by the Departments of Mental Health and Education as emergency regulations in 1998 and final regulations in 1999, constitute a reimbursable state-mandated program since the state "freely chose" to impose the costs upon counties as a means of implementing the federal IDEA program.

II. ELIGIBLE CLAIMANTS

Any county, or city and county, that incurs increased costs as a result of this reimbursable state-mandated program is eligible to claim reimbursement of those costs.

III. PERIOD OF REIMBURSEMENT

Government Code section 17557 states that a test claim shall be submitted on or before June 30 following a given fiscal year to establish eligibility for reimbursement for that fiscal year. The test claim for this mandate was filed by the County of Stanislaus (02-TC-40) on June 27, 2003, and filed by the County of Los Angeles (02-TC-49) on June 30, 2003. Therefore, the period of reimbursement begins July 1, 2001.

Actual costs for one fiscal year shall be included in each claim. Estimated costs for the subsequent year may be included on the same claim, if applicable. Pursuant to Government Code section 17561, subdivision (d)(l)(A), all claims for reimbursement of initial fiscal year costs shall be submitted to the State Controller within 120 days of the issuance date for the claiming instructions.

If the total costs for a given year do not exceed $1,000, no reimbursement shall be allowed, except as otherwise allowed by Government Code section 17564.

IV. REIMBURSABLE ACTIVITIES

To be eligible for mandated cost reimbursement for any given fiscal year, only actual costs may be claimed. Actual costs are those costs actually incurred to implement the mandated activities. Actual costs must be traceable and supported by source documents that show the validity of such costs, when they were incurred, and their relationship to the reimbursable activities. A source document is a document created at or near the same time the actual cost was incurred for the event or activity in question. Source documents may include, but are not limited to, employee time records or time logs, sign-in sheets, invoices, and receipts.

Evidence corroborating the source documents may include, but is not limited to, worksheets, cost allocation reports (system generated), purchase orders, contracts, agendas, calendars, and declarations. Declarations must include a certification or declaration stating, "I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct," and must further comply with the requirements of Code of Civil Procedure section 2015.5. Evidence corroborating the source documents may include data relevant to the reimbursable activities otherwise reported in compliance with local, state, and federal government requirements. However, corroborating documents cannot be substituted for source documents.

The claimant is only allowed to claim and be reimbursed for increased costs for reimbursable activities identified below. Claims should *exclude* reimbursable costs included in claims previously filed, beginning in fiscal year 2001-2002, for the Handicapped and Disabled Students program (CSM 4282).[1] Increased cost is limited to the cost of an activity that the claimant is required to incur as a result of the mandate.

[1] Some costs disallowed by the State Controller's Office in prior years are now reimbursable beginning July 1, 2001 (e.g., medication monitoring). Rather than claimants re-filing claims for

For each eligible claimant, the following activities are eligible for reimbursement:

A. Interagency Agreements (Cal. Code Regs., tit. 2, § 60030)

The one-time activity of revising the interagency agreement with each local educational agency to include the following eight procedures:

1) Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code section 7575, subdivision (f). For purposes of this subdivision only, the term "appropriate" means any service identified in the pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(2).)

2) A host county to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)

3) Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)

4) At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)

5) The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)

6) The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)

7) The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)

8) Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)

(The activities of updating or renewing the interagency agreements are not reimbursable.)

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those costs incurred beginning July 1, 2001, the State Controller's Office will reissue the audit reports.

B. Referral and Mental Health Assessments (Gov. Code, § 7576; Cal. Code Regs., tit. 2, §§ 60040, 60045)

1) Work collaboratively with the local educational agency to ensure that assessments performed prior to referral are as useful as possible to the community mental health service in determining the need for mental health services and the level of services needed. (Gov. Code, § 7576, subd. (b)(1).)

2) A county that receives a referral for a pupil with a different county of origin shall forward the referral within one working day to the county of origin. (Gov. Code, § 7576, subd. (g); Cal. Code Regs., tit. 2, § 60040, subd. (g).)

3) If the county determines that a mental health assessment is not necessary, the county shall document the reasons and notify the parents and the local educational agency of the county determination within one day. (Cal Code Regs., tit. 2, § 60045, subd. (a)(1).)

4) If the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral. (Cal. Code Regs., tit. 2, § 60045, subd. (a)(2).)

5) Notify the local educational agency when an assessment is determined necessary. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)

6) Provide the assessment plan to the parent. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)

7) Report back to the referring local educational agency or IEP team within 30 days from the date of the receipt of the referral if no parental consent for a mental health assessment has been obtained. (Cal. Code Regs., tit. 2, § 60045, subd. (c).)

8) Notify the local educational agency within one working day after receipt of the parent's written consent for the mental health assessment to establish the date of the IEP meeting. (Cal. Code Regs., tit. 2, § 60045, subd. (d).)

9) Provide the parent with written notification that the parent may require the assessor to attend the IEP meeting to discuss the recommendation when the parent disagrees with the assessor's mental health service recommendation. (Cal. Code Regs., tit. 2, § 60045, subd. (f).)

10) The county of origin shall prepare yearly IEP reassessments to determine the needs of a pupil. (Cal. Code Regs., tit. 2, § 60045, subd. (h).)

C. Transfers and Interim Placements (Cal. Code Regs., tit. 2, § 60055)

1) Following a pupil's transfer to a new school district, the county shall provide interim mental health services, as specified in the existing IEP, for thirty days, unless the parent agrees otherwise.

2) Participate as a member of the IEP team of a transfer pupil to review the interim services and make a determination of services.

D. Participate as a Member of the Expanded IEP Team When Residential Placement of a Pupil is Recommended (Gov. Code, § 7572.55; Cal Code Regs., tit. 2, § 60100)

1) When a recommendation is made that a child be placed in an out-of-state residential facility, the expanded IEP team, with the county as a participant, shall develop a plan for using less restrictive alternatives and in-state alternatives as soon as they become available, unless it is in the best educational interest of the child to remain in the out-of-state school. (Gov. Code, § 7572.55, subd. (c).)

2) The expanded IEP team, with the county as a participant, shall document the alternatives to residential placement that were considered and the reasons why they were rejected. (Cal. Code Regs., tit. 2, § 60100, subd. (c).)

3) The expanded IEP team, with the county as a participant, shall ensure that placement is in accordance with the admission criteria of the facility. (Cal. Code Regs., tit. 2, § 60100, subd. (j).)

4) When the expanded IEP team determines that it is necessary to place a pupil who is seriously emotionally disturbed in residential care, counties shall ensure that: (1) the mental health services are specified in the IEP in accordance with federal law, and (2) the mental health services are provided by qualified mental health professionals. (Cal. Code Regs., tit. 2, § 60100, subd. (i).)

E. Case Management Duties for Pupils Placed in Residential Care (Cal. Code Regs., tit. 2, §§ 60100, 60110)

1) Coordinate the residential placement plan of a pupil with a disability who is seriously emotionally disturbed as soon as possible after the decision has been made to place the pupil in residential placement. The residential placement plan shall include provisions, as determined in the pupil's IEP, for the care, supervision, mental health treatment, psychotropic medication monitoring, if required, and education of the pupil. (Cal. Code Regs., tit, 2, § 60110, subd, (b)(1).)

2) When the IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a community treatment facility, the lead case manager shall ensure that placement is in accordance with admission, continuing stay, and discharge criteria of the community treatment facility. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(3).)

3) Identify, in consultation with the IEP team's administrative designée, a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost-effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment. (Cal. Code Regs, tit. 2, §§ 60100, subd. (e), 60110, subd. (c)(2).)

4) Document the determination that no nearby placement alternative that is able to implement the IEP can be identified and seek an appropriate placement that is as close to the parents' home as possible. (Cal. Code Regs., tit. 2, § 60100, subd. (f).)

5) Notify the local educational agency that the placement has been arranged and coordinate the transportation of the pupil to the facility if needed. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(7).)

6) Facilitate placement authorization from the county's interagency placement committee pursuant to Welfare and Institutions Code section 4094.5, subdivision (e)(1), by presenting the case of a pupil with a disability who is seriously emotionally disturbed prior to placement in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(11).)

7) Evaluate every 90 days the continuing stay criteria, as defined in Welfare and Institutions Code section 4094, of a pupil placed in a community treatment facility every 90 days. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(8).)

8) Schedule and attend the next expanded IEP team meeting with the expanded IEP team's administrative designee within six months of the residential placement of a pupil with a disability who is seriously emotionally disturbed and every six months thereafter as the pupil remains in residential placement. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(10).)

F. Authorize Payments to Out-Of-Home Residential Care Providers (Cal. Code Regs., tit. 2, § 60200, subd. (e))

1) Authorize payments to residential facilities based on rates established by the Department of Social Services in accordance with Welfare and Institutions Code sections 18350 and 18356. This activity requires counties to determine that the residential placement meets all the criteria established in Welfare and Institutions Code sections 18350 through 18356 before authorizing payment.

G. Provide Psychotherapy or Other Mental Health Treatment Services (Cal. Code Regs., tit. 2, §§ 60020, subd. (i), 60050, subd. (b), 60200, subd. (c))

1) The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)

2) The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)

3) Provide case management services to a pupil when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

4) Provide individual or group psychotherapy services, as defined in Business and Professions Code section 2903, when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

5) Provide medication monitoring services when required by the pupil's IEP. "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication

support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subds. (f) and (i).)

6) Notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of a service, or when the pupil is no longer participating in treatment. ((Cal. Code Regs., tit. 2, § 60050, subd. (b).)

(When providing psychotherapy or other mental health treatment services, the activities of mental health assessments, collateral services, intensive day treatment, case management, crisis intervention, vocational services, and socialization services are not reimbursable.)

V. CLAIM PREPARATION AND SUBMISSION

Each of the following cost elements must be identified for each reimbursable activity identified in section IV. of this document. Each claimed reimbursable cost must be supported by source documentation as described in section IV. Additionally, each reimbursement claim must be filed in a timely manner.

A. Direct Cost Reporting

Direct costs are those costs incurred specifically for the reimbursable activities. The following direct costs are eligible for reimbursement.

1. Salaries and Benefits

Report each employee implementing the reimbursable activities by name, job classification, and productive hourly rate (total wages and related benefits divided by productive hours). Describe the specific reimbursable activities performed and the hours devoted to each reimbursable activity performed.

2. Materials and Supplies

Report the cost of materials and supplies that have been consumed or expended for the purpose of the reimbursable activities. Purchases shall be claimed at the actual price after deducting discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged on an appropriate and recognized method of costing, consistently applied.

3. Contracted Services

Report the name of the contractor and services performed to implement the reimbursable activities. If the contractor bills for time and materials, report the number of hours spent on the activities and all costs charged. If the contract is a fixed price, report the services that were performed during the period covered by the reimbursement claim. If the contract services are also used for purposes other than the reimbursable activities, only the pro-rata portion of the services used to implement the reimbursable activities can be claimed. Submit contract consultant and invoices with the claim and a description of the contract scope of services.

4. Fixed Assets and Equipment

Report the purchase price paid for fixed assets and equipment (including computers) necessary to implement the reimbursable activities. The purchase price includes taxes, delivery costs, and installation costs. If the fixed asset or equipment is also used for purposes other than the reimbursable activities, only the pro-rata portion of the purchase price used to implement the reimbursable activities can be claimed.

B. Indirect Cost Rates

Indirect costs are costs that are incurred for a common or joint purpose, benefiting more than one program, and are not directly assignable to a particular department or program without efforts disproportionate to the result achieved. Indirect costs may include (1) the overhead costs of the unit performing the mandate; and (2) the costs of the central government services distributed to the other departments based on a systematic and rational basis through a cost allocation plan.

Compensation for indirect costs is eligible for reimbursement utilizing the procedure provided in the Office of Management and Budget (OMB) Circular A-87. Claimants have the option of using 10% of labor, excluding fringe benefits, or preparing an Indirect Cost Rate Proposal (ICRP) if the indirect cost rate claimed exceeds 10%.

If the claimant chooses to prepare an ICRP, both the direct costs (as defined and described in OMB Circular A-87 Attachments A and B) and the indirect costs shall exclude capital expenditures and unallowable costs (as defined and described in OMB A-87 Attachments A and B). However, unallowable costs must be included in the direct costs if they represent activities to which indirect costs are properly allocable.

The distribution base may be (1) total direct costs (excluding capital expenditures and other distorting items, such as pass-through funds, major subcontracts, etc.), (2) direct salaries and wages, or (3) another base which results in an equitable distribution.

In calculating an ICRP, the claimant shall have the choice of one of the following methodologies:

1. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) classifying a department's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate which is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected; or
2. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) separating a department into groups, such as divisions or sections, and then classifying the division's or section's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate that is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected.

VI. RECORDS RETENTION

Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district pursuant to this chapter[2] is subject to the initiation of an audit by the State Controller no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the Controller to initiate an audit shall commence to run from the date of initial payment of the claim. All documents used to support the reimbursable activities, as described in Section IV, must be retained during the period subject to audit. If an audit has been initiated by the Controller during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings.

VII. OFFSETTING SAVINGS AND REIMBURSEMENTS

Any offsetting savings the claimant experiences in the same program as a result of the same statutes or executive orders found to contain the mandate shall be deducted from the costs claimed. In addition, reimbursement for this mandate received from any of the following sources shall be identified and deducted from this claim:

1. Funds received by a county pursuant to Government Code section 7576.5.
2. Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes the appropriation made by the Legislature in the Budget Act of 2001, which appropriated funds to counties in the amounts of $12,334,000 (Stats. 2001, ch. 106, items 4440-131-0001), and the $69 million appropriations in 2003 and 2004 (Stats. 2003, ch. 157, item 6110-161-0890, provision 17; Stats. 2004, ch. 208, item 6110-161-0890, provision 10).
3. Private insurance proceeds obtained with the consent of a parent for purposes of this program.
4. Medi-Cal proceeds obtained from the state or federal government that pay for a portion of the county services provided to a pupil under the Handicapped and Disabled Students program in accordance with federal law.
5. Any other reimbursement received from the federal or state government, or other non-local source.

Beginning July 1, 2001, realignment funds under the Bronzan-McCorquodale Act that are used by a county for this program are not required to be deducted from the costs claimed. (Stats. 2004, ch. 493, § 6 (SB 1895).)

VIII. STATE CONTROLLER'S CLAIMING INSTRUCTIONS

Pursuant to Government Code section 17558, subdivision (b), the Controller shall issue claiming instructions for each mandate that requires state reimbursement not later than 60 days after receiving the adopted parameters and guidelines from the Commission, to assist local agencies and school districts in claiming costs to be reimbursed. The claiming instructions shall be derived from the statute or executive order creating the mandate and the parameters and guidelines adopted by the Commission.

[2] This refers to Title 2, division 4, part 7, chapter 4 of the Government Code.

Pursuant to Government Code section 17561, subdivision (d)(1), issuance of the claiming instructions shall constitute a notice of the right of the local agencies and school districts to file reimbursement claims, based upon parameters and guidelines adopted by the Commission.

IX. REMEDIES BEFORE THE COMMISSION

Upon request of a local agency or school district, the Commission shall review the claiming instructions issued by the State Controller or any other authorized state agency for reimbursement of mandated costs pursuant to Government Code section 17571. If the Commission determines that the claiming instructions do not conform to the parameters and guidelines, the Commission shall direct the Controller to modify the claiming instructions to conform to the parameters and guidelines as directed by the Commission.

In addition, requests may be made to amend parameters and guidelines pursuant to Government Code section 17557, subdivision (a), and the California Code of Regulations, title 2, section 1183.2.

X. LEGAL AND FACTUAL BASIS FOR THE PARAMETERS AND GUIDELINES

The Statement of Decision is legally binding on all parties and provides the legal and factual basis for the parameters and guidelines. The support for the legal and factual findings is found in the administrative record for the test claim. The administrative record, including the Statement of Decision, is on file with the Commission.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561

HANDICAPPED AND DISABLED STUDENTS II

For State Controller Use Only	Program
(19) Program Number 00263	263
(20) Date Filed ___/___/___	
(21) LRS Input ___/___/___	

LABEL HERE

(01) Claimant Identification Number			Reimbursement Claim Data	
(02) Claimant Name			(22) HDS -1, (04)(A)(1)(f)	
County of Location			(23) HDS -1, (04)(B)(1)(f)	
Street Address or P.O. Box — Suite			(24) HDS -1, (04)(C)(1)(f)	
City — State — Zip Code			(25) HDS -1, (04)(D)(1)(f)	
Type of Claim	Estimated Claim	Reimbursement Claim	(26) HDS -1, (04)(E)(1)(f)	
	(03) Estimated ☐	(09) Reimbursement ☐	(27) HDS -1, (04)(F)(1)(f)	
	(04) Combined ☐	(10) Combined ☐	(28) HDS -1, (04)(G)(1)(f)	
	(05) Amended ☐	(11) Amended ☐	(29) HDS -1, (06)	
Fiscal Year of Cost	(06) ___/___	(12) ___/___	(30) HDS -1, (07)	
Total Claimed Amount	(07)	(13)	(31) HDS -1, (09)	
Less: 10% Late Penalty		(14)	(32) HDS -1, (10)	
Less: Prior Claim Payment Received		(15)	(33)	
Net Claimed Amount		(16)	(34)	
Due from State	(08)	(17)	(35)	
Due to State		(18)	(36)	

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code Section 17561, I certify that I am the officer authorized by the local agency to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1098, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein, and such costs are for a new program or increased level of services of an existing program. All offsetting savings and reimbursements set forth in the Parameters and Guidelines are identified, and all costs claimed are supported by source documentation currently maintained by the claimant.

The amounts for this Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Authorized Officer ______________________ Date ______________________

Type or Print Name ______________________ Title ______________________

(38) Name of Contact Person for Claim ______________________ Telephone Number ( ) - Ext.

E-Mail Address ______________________

Program 263	HANDICAPPED AND DISABLED STUDENTS II Certification Claim Form Instructions	FORM FAM-27

(01) Enter the payee number assigned by the State Controller's Office.

(02) Enter your Official Name, County of Location, Street or P. O. Box address, City, State, and Zip Code.

(03) If filing an estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing a combined estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended estimated claim, enter an "X" in the box on line (05) Amended.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of the estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form HDS-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing a combined reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended reimbursement claim, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 and supporting schedules for each fiscal year.

(13) Enter the amount of the reimbursement claim from form HDS-1, line (11). The total claimed amount must exceed $1,000.

(14) Claims for fiscal years 2001-02 to 2004-05 must be filed with the SCO and be delivered or postmarked on or before June 19, 2006. Actual reimbursement claims for fiscal year 2005-06 and estimated claims for fiscal year 2006-07 must be filed on or before January 16, 2007, or the claims shall be reduced by a late penalty. Enter zero if the claim was timely filed, otherwise, enter the product of multiplying line (13) by the factor (0.10% penalty).

(15) If filing an actual reimbursement claim and an estimated claim was previously filed for the same fiscal year, enter the amount received for the claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14), and line (15), from line (13).

(17) If line (16), Net Claimed Amount, is positive, enter that amount on line (17), Due from State.

(18) If line (16), Net Claimed Amount, is negative, enter that amount on line (18), Due to State.

(19) to (21) Leave blank.

(22) to (36) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (36) for the reimbursement claim, e.g. HDS-1, (04)(A)(f), means the information is located on form HDS-1, block (04), line (A), column (f). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, i.e., no cents. Indirect costs percentage should be shown as a whole number and without the percent symbol, i.e., 35.19% should be shown as 35. Completion of this data block will expedite the payment process.

(37) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the district's authorized officer, and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by an original signed certification. (To expedite the payment process, please sign the form FAM-27 with blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)

(38) Enter the name, telephone number, and e-mail address of the person to contact if additional information is required.

Claims should be rounded to the nearest dollar. Submit a signed original and a copy of form FAM-27, Claim for Payment, and all other forms and supporting documents. Use the following mailing addresses:

Address, if delivered by U.S. Postal Service:	*Address, if delivered by other delivery service:*
OFFICE OF THE STATE CONTROLLER **ATTN: Local Reimbursements Section** **Division of Accounting and Reporting** **P.O. Box 942850** **Sacramento, CA 94250**	**OFFICE OF THE STATE CONTROLLER** **ATTN: Local Reimbursements Section** **Division of Accounting and Reporting** **3301 C Street, Suite 500** **Sacramento, CA 95816**

Program 263 | MANDATED COSTS — HANDICAPPED AND DISABLED STUDENTS II — CLAIM SUMMARY | **FORM HDS-1**

(01) Claimant				(02) Type of Claim: Reimbursement ☐ Estimated ☐			Fiscal Year ___ / ___
Claim Statistics							
(03) Number of student referrals during the fiscal year of claim							
Direct Costs	**Object Accounts**						
(04) Reimbursable Activities	(a) Salaries	(b) Benefits	(c) Materials and Supplies	(d) Contracted Services	(e) Fixed Assets	(f) Total	
A. Interagency Agreements							
B. Referral and Mental Health Assessments							
C. Transfers and Interim Placements							
D. Membership Participation of Expanded IEP Team							
E. Case Management Duties for Pupils							
F. Payment Authorization to Care Providers							
G. Psychotherapy or Other Treatment Services							
(05) Total Direct Costs							
Indirect Costs							
(06) Indirect Cost Rate	[10% or ICRP from 2 CFR, Chapter II, formerly OMB A-87]					%	
(07) Total Indirect Costs	[Line (06) x line (05)(a)] or [Line (06) x {line (05)(a) + line (05)(b)}]						
(08) Total Direct and Indirect Costs	[Line (05)(f) + line (07)]						
Cost Reduction							
(09) Less: Offsetting Savings							
(10) Less: Other Reimbursements							
(11) Total Claimed Amount	[Line (08) - {line (09) + line (10)}]						

Program 263 | HANDICAPPED AND DISABLED STUDENTS II — CLAIM SUMMARY — Instructions | **FORM HDS-1**

(01) Enter the name of the claimant. If more than one department has incurred costs for this mandate, give the name of each department. A form HDS-1 should be completed for each department.

(02) Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year of costs.

Form HDS-1 must be filed for a reimbursement claim. Do not complete form HDS-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form HDS-1 must be completed and a statement attached explaining the increased costs. Without this information the estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Enter the number of students who were referred during the fiscal year of claim.

(04) For each reimbursable activity, enter the total from form HDS-2, line (05), columns (d) through (i) to form HDS-1, block (04), columns (a) through (f) in the appropriate row. Total each row.

(05) Total columns (a) through (f).

(06) Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have its own ICRP for the program.

(07) Multiply Total Salaries, line (05)(a), by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (05)(a), and Total Benefits, line (05)(b), by the Indirect Cost Rate, line (06).

(08) Enter the sum of Total Direct Costs, line (05)(f), and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings. If applicable, enter the total savings experienced by the claimant as a result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements. If applicable, enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, that reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. From Total Direct and Indirect Costs, line (08), subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

Program 263

MANDATED COSTS
HANDICAPPED AND DISABLED STUDENTS II
ACTIVITY COST DETAIL

FORM HDS-2

(01) Claimant | (02) Fiscal Year

(03) Reimbursable Activities: Check only one box per form to identify the activity being claimed.

- [ ] Interagency Agreements
- [ ] Case Management Duties for Pupils
- [ ] Referral and Mental Health Assessments
- [ ] Payment Authorization to Care Providers
- [ ] Transfers and Interim Placements
- [ ] Psychotherapy or Other Treatment Services
- [ ] Member Participation of Extended IEP Team

(04) Description of Expenses			Object Accounts				
(a) Employee Names, Job Classifications, Functions Performed and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Materials and Supplies	(g) Contracted Services	(h) Fixed Assets
(05) Total [ ] Subtotal [ ] Page: ____of____							

New 02/06

State Controller's Office — Mandated Cost Manual

Program 263

HANDICAPPED AND DISABLED STUDENTS II
COMPONENT/ACTIVITY COST DETAIL
Instructions

FORM HDS-2

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred.

(03) Check the box which indicates the activity being claimed. Check only one box per form. A separate form HDS-2 shall be prepared for each applicable activity.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, and contracted services expenses. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than three years after the date the claim was filed or last amended, whichever is later. If no funds were appropriated and no payment was made at the time the claim was filed, the time for the Controller to initiate an audit shall be from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub-object Accounts	Columns								Submit supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	
Salaries	Employee Name/Title	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked					
Benefits	Activities Performed	Benefit Rate			Benefits = Benefit Rate x Salaries				
Materials and Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost= Unit Cost X Quantity Used			
Contracted Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service				Itemized Cost of Services Performed		Copy of Contract and Invoice
Fixed Assets	Description of Equipment Purchased	Unit Cost	Usage					Cost= Unit Cost x Usage	

(05) Total line (04), columns (d) through (h) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the activity costs, number each page. Enter totals from line (05), columns (d) through (h) to form HDS-1, block (04), columns (a) through (e) in the appropriate row.

New 02/06

06 MAY 16 PM 1:25

EXHIBIT C

Excellence
Integrity
Service

COUNTY OF ORANGE
HEALTH CARE AGENCY

BEHAVIORAL HEALTH SERVICES

DAVID L. RILEY
DIRECTOR

MARK A. REFOWITZ
DEPUTY AGENCY DIRECTOR
BEHAVIORAL HEALTH SERVICES

MAILING ADDRESS:
405 W. 5th STREET, 7TH FLOOR
SANTA ANA, CA 92701

TELEPHONE: (714) 834-6032
FAX: (714) 834-5506
E-MAIL: mrefowitz@ochca.com

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NOV 0 9 2009
COMMISSION ON STATE MANDATES

November 3, 2009 CERTIFIED MAIL

Nancy Patton, Asst. Executive Director
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814

Ginny Brummels
Division of Accounting and Reporting
State Controller's Office
3301 C Street, Suite 700
Sacramento, CA 95816

Re: Incorrect Reduction Claim for
Handicapped and Disabled Students Claim
Fiscal Years 1997-98 and 1998-99
County of Orange, Claimant

Ms. Patton and Ms. Brummels,

This letter is to serve as our written rebuttal to the State Controller's Office letter dated 10/6/2009 **(attachment A)** per California Code of Regulations. TITLE 2, DIVISION 2., CHAPTER 2.5. ARTICLE 5. § 1185.1. (c).

<u>Reduction of Medication Monitoring</u>

The State's position is that medication monitoring "was not included in the adoption of the parameters and guidelines as a reimbursable cost." In fact, the guidelines state that "*Any costs* related to the mental health treatment services rendered under the Short Doyle act" are reimbursable **(attachment B)**. While the guidelines go on to say that certain specific treatment services are eligible; and medication monitoring is not mentioned specifically, it is not excluded either. There is no disputing the fact that medication monitoring was a mental health treatment service rendered under the Short Doyle act. Per the State's response they concur with the fact that medication monitoring was defined in regulation at the time the parameters were adopted. There is no mention in the Parameters and Guidelines that the listing of services was an all inclusive list.

The original audit report states "...since Medication Monitoring and Crisis Intervention...were not included as reimbursable costs, the only reasonable conclusion is that they were intentionally excluded and, therefore, not reimbursable." **(attachment C)**

Their "reasonable conclusion" has since come under question given the adoption of HDS II and its inclusion of medication monitoring. The parameters and guidelines are not the mandate itself, but a tool used to claim for services mandated by the State. HDS II allows us to go back to July 2001, and unless that mandate on the County had changed from June 2001 to July 2001, the mandate on the County existed at the time of the claim in question. The SCO asserts that, according to the HDS II test claim, counties were seeking reimbursement for activities required by statutory amendments to the original HDS program, and that these amendments included medication monitoring. However according to the HDS II corrected P's and G's submitted with the SCO rebuttal, even the prior regulations included medication monitoring **(see attachment D)**. The inclusion of medication monitoring in these specific regulations was also a point brought up in our original audit response **(attachment E.)**

The SCO also contends that the dates set forth in HDS II define the period of reimbursement for the amended portions beginning July 1, 2001 and as a result of that fact the Counties cannot claim for these services. We would like to point out that we are not claiming reimbursement under HDS II, we are simply using the fact that medication monitoring has since been found to be a part of the mandate and in light of this fact the SCO's "reasonable conclusion" is no longer reasonable. There was no underlying change in the program that took place beginning July 2001. We would have to, barring any clarification, assume that medication monitoring has always been allowable since the original P's and G's are silent on the matter.

Per the State Controller's Office response, the Controller's Office is empowered to audit claims for mandated costs and to reduce those that are "excessive or unreasonable." Given this directive the County feels that the SCO incorrectly came to a conclusion using an assumption (or "reasonable conclusion"). With HDS II's inclusion of medication monitoring it is apparent that medication monitoring costs were neither excessive nor unreasonable. Even at the time of the audit (before HDS II) the County believes that the auditor was incorrect in making assumptions to deprive the county of millions of dollars. Medication monitoring was never excluded in the Parameters and Guidelines, and has always been part of the treatment services rendered under the Short Doyle act. There was no proof at the time of the original audit that these costs were excessive or unreasonable, and since HDS II there is actually evidence against that assumption.

Statute of Limitations

The SCO contends that our claim is late because it was filed on May 1, 2006. The letter was actually mailed April 28, 2006. The May 1st date the SCO references was the date received by the Commission. This is an important distinction because TITLE 2. California Code of Regulations, DIVISION 2., CHAPTER 2.5. ARTICLE 1. § 1181.1(g) states:

"Filing date" means the date of delivery to the commission's office during normal business hours. For purposes of meeting the filing deadlines required by statute, **the filing is timely if:**

(1) the filing was mailed by certified or express mail or a common carrier promising overnight delivery, and

(2) **the time for its filing had not expired on the date of its *mailing*** by certified or express mail as shown on the postal receipt or postmark, or the date of its delivery to a common carrier promising overnight delivery as shown on the carrier's receipt. **(attachment F)**

The claim was *mailed* on April 28, 2006 and was received on May 1, 2006.

The County would also like to point out that s 1185.01(b) states:

Commission staff shall notify the Office of State Controller that written oppositions or recommendations and supporting documentation in connection with an incorrect reduction claim shall be filed no more than ninety (90) days from the date the copy of the claim is provided to the Office of State Controller. The Office of State Controller shall simultaneously serve a copy of any opposition or recommendation regarding the claim on the claimant and their designated representative or, if a mailing list is provided by the commission, a copy of any opposition or recommendation on the claim, must be filed on all parties and interested parties on the mailing list. **(attachment G)**

The letter we received from the Commission was dated 5/12/06, the SCO response was dated 10/6/09. The county was to receive the SCO rebuttal *no more than ninety (90) days from the date the copy of the claim is provided to the Office of State Controller* (simultaneously with the submission to the Commission.) Given the extreme delay caused by the State's submission the County would like the State's arguments removed from the discussion.

A three year delay is unacceptable as many key personnel have moved on to different positions and records may be lost. Fortunately we were able to maintain control over our records, but the fact that this rebuttal is untimely places the County in a difficult position since we have the burden of proof, not to mention it is also in violation of California Regulations. Also, per the commissions letter **(attachment H)**, "The failure of the SCO to respond within the 90 day timeline shall not cause the commission to delay consideration of this IRC." When, in fact, that is exactly what has happened. The County believes that this process should move forward without the SCO position being considered.

Conclusion

Medication monitoring is, and has always been, a part of the mandate on the County to provide mental health services to students. The fact that the Parameters and Guidelines did not enumerate this activity specifically is not basis to determine the activity was unreasonable or excessive. The facts clearly show that medication monitoring falls under the scope of mental health treatment services and those services were allowable under the original Parameters and Guidelines.

Sincerely,

Mark A. Refowitz
Behavioral Health Director

Attachments

JOHN CHIANG
California State Controller

October 6, 2009

Nancy Patton, Asst. Executive Director
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814

Bang Quan
Auditor-Controller, Orange County
P.O. Box 567
Santa Ana, CA 92702

Re: **Incorrect Reduction Claim**
Handicapped and Disabled Students, 05-4282-I-02
County of Orange, Claimant
Statutes 1984, Chapter 1747; Statutes 1985, Chapter 1274
Fiscal Years 1997-98 and 1998-99

Dear Ms. Patton and Ms. Quan:

This letter is in response to the above-entitled Incorrect Reduction Claim. The subject claims were reduced because the Claimant included costs for services that were not reimbursable under the Parameters & Guidelines in effect during the audited years. In addition, the Incorrect Reduction Claim should be denied because it was filed after the expiration of the deadline provided for in regulation. The reductions were appropriate and in accordance with law.

The Controller's Office is empowered to audit claims for mandated costs and to reduce those that are "excessive or unreasonable."[1] This power has been affirmed in recent cases, such as the Incorrect Reductions Claims (IRCs) for the *Graduation Requirements* mandate.[2] If the claimant disputes the adjustments made by the Controller pursuant to that power, the burden is upon it to demonstrate that it is entitled to the full amount of the claim. This principle likewise has been upheld in the *Graduation Requirements* line of IRCs.[3] See also Evidence Code section 500.[4] In this case, the audit determined that the Claimant was claiming costs for medication monitoring, which was not an identified reimbursable activity in the Parameters & Guidelines as amended in 1996, and effective for the two fiscal years that were the subject of this audit. Therefore, these claimed costs are unsupportable and thus, disallowed.

---

[1] See Government Code section 17561, subdivisions (d)(1)(C) and (d)(2), and section 17564.
[2] See for example, the Statement of Decision in the Incorrect Reduction Claim of San Diego Unified School District [No. CSM 4435-I-01 and 4435-I-37], adopted September 28, 2000, at page 9.
[3] See for example, the Statement of Decision in the Incorrect Reduction Claim of San Diego Unified School District [No. CSM 4435-I-01 and 4435-I-37], adopted September 28, 2000, at page 16.
[4] "Except as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting."

300 Capitol Mall, Suite 1850, Sacramento, CA 95814 ♦ P.O. Box 942850, Sacramento, CA 94250
Phone: (916) 445-2636 ♦ Fax: (916) 322-1220

The Claimant points to subsequent amendments of the Parameters & Guidelines adopted in 2005 and 2006, which refer to medication monitoring, to support its claim that it is a reimbursable cost. However, amendments to Parameters & Guidelines are not retroactive, and the amendments in question were only effective from July 1, 2001, forward, therefore, they did not apply to the fiscal years audited. In fact, the addition of medication monitoring as a reimbursable activity supports the Controller's position in this case; it does not contradict it, as the Claimant asserts. If medication monitoring had been covered in the prior Parameters & Guidelines, there would have been no need to add an explicit reference to the activity in the amendments. Therefore, medication monitoring was not a reimbursable activity prior to July 1, 2001.

In addition, the Claimant failed to file its Incorrect Reduction Claim in the time frame required by Title 2 of the California Code of Regulations, Section 1185. Section 1185, subdivision (b) states that "[a]ll incorrect reduction claims shall be filed with the commission no later than three (3) years following the date of the Office of State Controller's remittance advice or other notice of adjustment notifying the claimant of a reduction." In this case, the remittance advice and accompanying letter were dated April 28, 2003 (See pages 2-5 of Exhibit C of the Claimant's IRC). Therefore, the last date to file an IRC was April 28, 2003. However, the Claimant did not file its claim until May 1, 2003, outside the time frame provided, and thus, the IRC is precluded by the limitations provision of Section 1185.

Enclosed please find a complete detailed analysis from our Division of Audits, exhibits, and supporting documentation with declaration.

Sincerely,

Shawn D. Silva

SHAWN D. SILVA
Senior Staff Counsel

SDS/ac

Enclosure

cc: Denise Steckler, Manager, Financial Reporting & Mandated Costs, Orange County
Ginny Brummels, Division of Accounting & Reporting, State Controller's Office (w/o encl.)
Jim Spano, Division of Audits, State Controller's Office (w/o encl.)

emotionally disturbed", and any member of the IEP team recommends [illegible] placement based upon relevant assessment information, inclusion of the claimant's mental health professional on that individual's expanded IEP tea[illegible]

(f) When the IEP prescribes residential placement for an "individual with exceptio[illegible] needs" who is "seriously emotionally disturbed," claimant's mental health personnel's identification of out-of-home placement, case management, six month review of IEP, and expanded IEP responsibilities. (G. C. § 7572.5).

(g) Required participation in due process procedures, including but not limited to due process hearings.

(b) One hundred (100%) percent of any administrative costs related to IEP Participation, Assessment, and Case Management, whether direct or indirect.

B. **Treatment Services**

Any costs related to mental health treatment services rendered under the Short-Doyle Act:

(1) The scope of the mandate is ten (10%) percent reimbursement.

(2) For each eligible claimant, the following cost items for the provision of mental health services when required by a child's individualized education program are ten (10%) percent reimbursable (G. C. § 7576):

(a) Individual therapy

(b) Collateral therapy and contacts

(c) Group therapy

(d) Day treatment

(e) Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.

(b) Ten (10%) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

7. **Reimbursement Limitations**

A. Any offsetting savings the claimant experiences as a direct result of this statute must be deducted from the costs claimed.

B. The following reimbursements for this mandate shall be deducted from the claim:

1. Any direct payments (categorical funding) received form the State which are specifically allocated to this program.

2. Any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g., federal, state, etc.

8. **Claiming Forms and Instructions**

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms HDS-1, HDS-2, HDS-3, HDS-4, HDS-5, and HDS-6 provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions should be duplicated and used by the claimant to file estimated or reimbursement claims. The State Controller's Office will revise the manual and claim forms as necessary. In such instances, new replacement forms will be mailed to claimants.

By citing the above code sections that mandate medication monitoring as a service provided under Chapter 26.5, the *Parameters and Guidelines* includes medication monitoring by implication and reference. That this service was not specifically listed in the guidelines was clearly an oversight and indicates that the *Parameters and Guidelines* need to be amended accordingly.

c) **Treatment Costs for Crisis Intervention**

The County does not concur that these are ineligible costs.

It was the intent of AB3632 and later amendments not to include mental health services designed to respond to "psychiatric emergencies or other situations requiring an immediate response" (Article 2, section 60040(e)). This language was related primarily to inpatient hospitalization. The services currently in dispute were not provided as psychiatric emergency services leading to hospitalization or other emergency care, but rather were provided in the normal course of mental health treatment. These services were provided as defined in the California Code of Regulations, Title 9, Section 543, and designed to alleviate problems which, if untreated, presented imminent threat to the pupil.

SCO's Comments

The finding and recommendation for ineligible case management costs for clients placed in out-of-state residential facilities, and treatment costs for medication support and crisis intervention, remain unchanged.

Case management costs incurred for handicapped and disabled students placed in out-of-state schools are an ineligible cost for the Handicapped and Disabled Students Program but are eligible under the Seriously Emotionally Disturbed Pupils: Out-of State Mental Health Services Program. *Parameters and Guidelines* for this program, adopted October 26, 2000, allows claimants to claim costs commencing on January 1, 1997.

Parameters and Guidelines, Section V(B)2, specifies the following treatment services, when required by a child's individualized education program (IEP), are reimbursable: individual therapy; collateral therapy and contacts; group therapy; day treatment; and the mental health portion of residential treatment in excess of the California Department of Social Services' payments for residential placement. Each treatment service above is defined under Title 9, Section 543 of the *California Administrative Code*. Since medication monitoring and crisis intervention were both defined in regulation at the time *Parameters and Guidelines* was adopted and were not included as reimbursable costs, the only reasonable conclusion is that they were intentionally excluded and, therefore, not reimbursable.

c

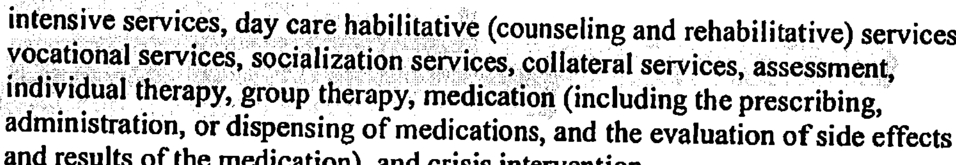
In addition, a correction is made to Section IV(G), Reimbursable Activities, "Providing Psychotherapy or Other Mental Health Treatment Services." On May 26, 2005, the Commission adopted the Statement of Decision in the reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10), and approved as a reimbursable state-mandated activity, beginning July 1, 2004, providing mental health assessments, collateral services, intensive day treatment, and day rehabilitation services when required by the pupil's IEP. When adopting the parameters and guidelines on the reconsidered program, the Commission determined that it would include psychotherapy and other mental health treatment activities in the parameters and guidelines in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), since it had an earlier reimbursement period (July 1, 2001) and the definition of mental health treatment services was substantially amended. The Commission's finding is as follows:

> The Commission's Statement of Decision authorizes reimbursement for providing psychotherapy or other mental health services identified in a pupil's IEP, as defined in sections 542 and 543 of the Department of Mental Health regulations. As noted in the Statement of Decision, however, the original definition of the types of services was repealed and replaced by the Departments of Mental Health and Education in 1998. [Footnote omitted.] The Commission concluded that the new definition of psychological and other mental health services constitutes a reimbursable new program or higher level of service in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) and, in December 2005, the Commission adopted parameters and guidelines for *Handicapped and Disabled Students II.* The reimbursement period for *Handicapped and Disabled Students II* begins July 1, 2001.
>
> Therefore, costs incurred by eligible claimants for the activity of providing psychological and other mental health services may be claimed pursuant to the parameters and guidelines in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), beginning July 1, 2001. Since the proposed parameters and guidelines for the reconsideration of the original *Handicapped and Disabled Students* program (04-RL-4282-10) has a later reimbursement period, the activity is not included in these proposed parameters and guidelines.[1]

On May 26, 2005, the Commission adopted the Statement of Decision in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) and found that section 60020 of the test claim regulations continued to include mental health assessments, collateral services, intensive day treatment, and day rehabilitation in the definition of "mental health services." However, the activities of crisis intervention, vocational services, and socialization services were deleted by the test claim regulations. The Commission also found that case management services were reimbursable. The Commission's findings are as follows:

> In addition, section 60020, subdivision (i), changed the definition of mental health services. As indicated above, the former regulations defined "psychotherapy and other mental health services" to include the day services and outpatient services identified in sections 542 and 543 of the Department of Mental Health regulations. (Former Cal. Code Regs., tit. 2, § 60020, subd. (a).) Under the prior regulations, these services included the following: day care

[1] Staff analysis adopted by Commission on January 26, 2006.



intensive services, day care habilitative (counseling and rehabilitative) services, vocational services, socialization services, collateral services, assessment, individual therapy, group therapy, medication (including the prescribing, administration, or dispensing of medications, and the evaluation of side effects and results of the medication), and crisis intervention.

Section 60020, subdivision (i), of the regulations, now defines "mental health services" as follows:

> "Mental health services" means mental health assessment and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code: psychotherapy as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management. These services shall be provided directly or by contract at the discretion of the community mental health service of the county of origin.

Section 60020 of the test claim regulations continues to include mental health assessments, collateral services, intensive day treatment, and day rehabilitation within the definition of "mental health services." These services are not new. [Footnote deleted.]

However, the activities of crisis intervention, vocational services, and socialization services were deleted by the test claim regulations. ...

Thus, counties are not eligible for reimbursement for providing crisis intervention, vocational services, and socialization services since these activities were repealed as of July 1, 1998.

Nevertheless, section 60020 of the regulations increases the level of service of counties providing mental health services by including case management services and "psychotherapy" within the meaning of "mental health services." The regulation defines psychotherapy to include both individual and group therapy, based on the definition in Business and Professions Code section 2903.

The parameters and guidelines for the program, however, inadvertently included in the identification of activities that were *not* reimbursable the activities of mental health assessments, collateral services, intensive day treatment, and case management. The parameters and guidelines also inadvertently did not include reimbursement for day rehabilitation services. Based on the Commission's Statements of Decision for these programs, claimants are eligible for reimbursement, beginning July 1, 2001, for case management services. Claimants are also eligible for reimbursement, beginning July 1, 2004, for mental health assessments, collateral services, intensive day treatment, and day rehabilitation services.

Thus, in order for the parameters and guidelines to conform to the findings of the Commission in the reconsideration of *Handicapped and Disabled Students* (04-RL-4292-10) and *Handicapped and Disabled Students II* (02-TC-40, 02-TC-49), Section IV(G) is corrected as follows:

G. Provide Psychotherapy or Other Mental Health Treatment Services (Cal. Code Regs., tit. 2, §§ 60020, subd. (i), 60050, subd. (b), 60200, subd. (c))

Health Services Program, and we have subsequently claimed these costs in the *SED* claim for Fiscal Years 1997-98, 1998-99, 1999-2000, and 2000-01.

However, at the time we filed the *Handicapped and Disabled Students Program* claims for Fiscal Years 1997-98 and 1998-99, which are the years being audited, the *SED Program* had not been identified as a mandated program, and the County believed that these costs were eligible to be claimed as part of the *Handicapped and Disabled Students Program* mandate. Claiming instructions for the *SED Program* were not issued until January 2001.

b) **Treatment Costs for Medication Support.**

The County does not concur that these are ineligible costs.

The *Parameters and Guidelines*, Summary of Mandates, references California Code of Regulations, Division 9, Sections 60000-60200. Title 2, as well as Division 7, Title 1 of the Government Code commencing with Section 7570. The *Parameters and Guidelines* specifically cites Government Code sections 7571 and 7576 and their implementing regulations as governance. The "implementing regulations" for the provision of Chapter 25.6 of the Government Code are found in the California Code of Regulations, Title 2, Division 9, the Joint Regulations for Handicapped Children.

Section 7576 (amended in 1996) of the Government Code identifies the Department of Mental Health's responsibility for the provision of Mental Health services and states, in part, that the Department of Mental Health "shall be responsible for the provision of mental health services as defined in regulations by the State Department of Mental Health, developed in connection with the State Department of Education, when required in the pupil's individualized education plan."

Additionally, the *Parameters and Guidelines* references Section 5651 of the Welfare and Institutions code which assures, in part, that "the county shall provide the mental health services required by Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code and will comply with all requirement of that chapter."

The California Code of Regulations in Section 60020(i) defines Mental Health services as such: "Mental Health services" means mental health assessments and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code: psychotherapy as defined in Section 2903 of the Business and Professions Code; provided to the pupil individually or in a group, collateral services, ***medication monitoring***, intensive day treatment, day rehabilitation, and case management. "Medication monitoring" is clearly defined in 60020(f) as including all medication support services including prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. The cost of the medications is not a covered service and has not been billed in the SB90 claiming process.

§ 1181.1. Definitions.

Unless otherwise indicated, the definitions in this chapter and those found in Government Code sections 17510 through 17524 apply to Articles 1, 2, 3, 4.5, 5, 6, 7, 8, and 8.5 of this chapter:

(a) "Affected state agency" means a state department or agency that is responsible, in whole or in part, for implementation, enforcement, or administration of any statute(s) or executive order(s) that is the subject of a claim.

(b) "Amendment" means the addition of new allegations based on new statutes or executive orders to an existing test claim. The addition or substitution of parties and supporting declarations based on the original statutes or executive orders alleged in an existing test claim is not an "amendment."

(c) "Claim" means test claim or incorrect reduction claim.

(d) "Claimant" means the local agency or school district filing a test claim or incorrect reduction claim.

(e) "Commission staff" means the executive director, legal counsel, or other commission employee authorized by the commission or the executive director to represent the commission on a specific claim or request, or to receive filings at the commission office.

(f) "Completed" means that all requirements for filing a claim, proposed parameters and guidelines, request to amend parameters and guidelines, request for reconsideration, or request to review claiming instructions have been satisfied by the claimant or requestor.

(g) "Filing date" means the date of delivery to the commission's office during normal business hours. For purposes of meeting the filing deadlines required by statute, the filing is timely if:

(1) the filing was mailed by certified or express mail or a common carrier promising overnight delivery, and

(2) the time for its filing had not expired on the date of its mailing by certified or express mail as shown on the postal receipt or postmark, or the date of its delivery to a common carrier promising overnight delivery as shown on the carrier's receipt.

(h) "Good cause" may include, but is not limited to, the following factors: (1) the number and complexity of the issues raised; (2) a party is new to the case, or other counsel is needed; (3) the individual responsible for preparing the document has other time-limited commitments during the affected period; (4) the individual responsible for appearing at the hearing has other time-limited commitments; (5) illness of a party; (6) a personal emergency; (7) a planned vacation that cannot reasonably be rearranged; (8) a pending public records request; and (9) any other factor, which in the context of a particular claim constitutes good cause. Good cause may be established by a specific showing of other obligations involving deadlines that as a practical matter preclude filing the document by the due date without impairing quality.

(i) "Incorrect reduction claim" means a claim alleging that the Office of State Controller incorrectly reduced the reimbursement claim of a local agency or school district.

(j) "Informational proceeding" means any hearing designed to gather and assess information to assist

the commission in formulating policies, informing the public of commission actions, or obtaining public comment and opinion.

(k) "Interested party" means a local agency or school district; an organization or association representing local agencies or school districts; or a person authorized to represent a local agency or school district, having an interest in a specific claim or request other than the claimant.

(l) "Interested person" means any individual, local agency, school district, state agency, corporation, partnership, association, or other type of entity, having an interest in the activities of the commission.

(m) "Party" means the test claimant, the Department of Finance, Office of State Controller, or affected state agency.

(n) "Rulemaking proceeding" means any hearing designed to adopt, amend, or repeal any rule, regulation, or standard of general application that implements, interprets, or makes specific any provision of Title 2, Division 4, Part 7, beginning with Government Code section 17500 or any other statute enforced or administered by the commission.

(o) "Statewide cost estimate" means the approximate sum of money that local agencies or school districts may have incurred to implement a state-mandated program or any increased level of service of an existing mandated program. A statewide cost estimate submitted by a test claimant shall be an estimate of the first full fiscal year of actual or estimated costs based on the statutes and executive orders alleged in a test claim, except as provided in Government Code section 17557.1, subdivision (a). A statewide cost estimate adopted by the commission shall be an estimate based on the commission's determination of a test claim for the initial period of reimbursement to be reported to the Legislature.

(p) "Statewide estimate of costs" is based on a reasonable reimbursement methodology proposed by a test claimant and the Department of Finance, adopted by the commission, and reported to the Legislature pursuant to Government Code section 17557.2.

(q) "Teleconference" means a conference of individuals in different locations, connected by electronic means, through audio, video, or both.

(r) "Written material" shall include, but is not limited to, requests and correspondence on substantive and procedural matters, e.g., informal conferences, prehearing conferences, postponements of hearings, extensions of due dates for submission of opposition, recommendations, comments, reasonable reimbursement methodologies, statewide estimates of costs, supplemental declarations, stipulations, applications for subpoenas and subpoenas duces tecum, witness lists, etc. Test claims, incorrect reduction claims, or amendments thereto, are not considered written material.

§ 1185.1. Review of Incorrect Reduction Claims.

(a) Within ten (10) days of receipt of a complete incorrect reduction claim, commission staff shall provide a copy of the claim to the Office of State Controller.

(b) Commission staff shall notify the Office of State Controller that written oppositions or recommendations and supporting documentation in connection with an incorrect reduction claim shall be filed no more than ninety (90) days from the date the copy of the claim is provided to the Office of State Controller. The Office of State Controller shall simultaneously serve a copy of any opposition or recommendation regarding the claim on the claimant and their designated representative or, if a mailing list is provided by the commission, a copy of any opposition or recommendation on the claim, must be filed on all parties and interested parties on the mailing list. Proof of service must be filed with the oppositions or recommendations and supporting documentation pursuant to section 1181.2. If the oppositions or recommendations regarding an incorrect reduction claim involve more than the discussion of statutes, regulations or legal argument and utilizes assertions or representations of fact, such assertions or representations shall be supported by documentary evidence and shall be submitted with the response. All documentary evidence must be authenticated by declarations under penalty of perjury signed by persons who are authorized and competent to do so and be based upon the declarant's personal knowledge or information or belief.

(c) The claimant and interested parties may submit written rebuttals to the Office of State Controller's comments. Written rebuttals shall be filed with the commission within thirty (30) days of service of the Office of State Controller's comments. The claimant shall simultaneously serve a copy of the written rebuttal on the Office of State Controller or, if a mailing list is provided by the commission, a copy of the rebuttal, must be served on all parties and interested parties on the mailing list. Proof of service shall be filed with the written rebuttal and supporting documentation pursuant to section 1181.2. If the written rebuttal involves more than discussion of statutes, regulations or legal argument and utilizes assertions or representations of fact, such assertions or representations shall be supported by documentary evidence and shall be submitted with the rebuttal. All documentary evidence must be authenticated by declarations under penalty of perjury signed by persons who are authorized and competent to do so and be based upon the declarant's personal knowledge or information or belief.

STATE OF CALIFORNIA ARNOLD SCHWARZENEGGER, Governor

COMMISSION ON STATE MANDATES
980 NINTH STREET, SUITE 300
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May 12, 2006

Ms. Bang Quan
County of Orange
Auditor-Controller
P.O. Box 567
Santa Ana, CA 92702

Ms. Ginny Brummels
Division of Accounting and Reporting
State Controller's Office
3301 C Street, Suite 501
Sacramento, CA 95816

Re: **Incorrect Reduction Claim**
Handicapped and Disabled Students, 05-4282-I-02
County of Orange, Claimant
Statutes 1984, Chapter 1747; Statutes 1985, Chapter 1274
Fiscal Years 1997-1998 and 1998-1999

Dear Ms. Quan and Ms. Brummels:

On May 1, 2006, the County of Orange filed an incorrect reduction claim (IRC) with the Commission on State Mandates (Commission) based on the *Handicapped and Disabled Students* program for fiscal years 1997-1998 and 1998-1999. Commission staff determined that the IRC filing is complete.

Government Code section 17551, subdivision (b), requires the Commission to hear and decide upon claims filed by local agencies and school districts that the State Controller's Office (SCO) has incorrectly reduced payments to the local agencies or school districts.

SCO Review and Response. Please file the SCO response and supporting documentation regarding this claim within 90 days of the date of this letter. Please include an explanation of the reason(s) for the reductions and the computation of reimbursements. All documentary evidence must be authenticated by declarations under penalty of perjury signed by persons who are authorized and competent to do so and be based on the declarant's personal knowledge, information or belief. The Commission's regulations also require that the responses (opposition or recommendation) filed with the Commission be simultaneously served on the claimants and their designated representatives, and accompanied by a proof of service. (Cal. Code Regs., tit. 2, § 1185.01.)

The failure of the SCO to respond within this 90-day timeline shall not cause the Commission to delay consideration of this IRC.

Claimant's Rebuttal. Upon receipt of the SCO response, the claimant and interested parties may file rebuttals. The rebuttals are due 30 days from the service date of the response.

PROOF OF SERVICE

I do hereby declare that I am a citizen of the United States employed in the County of Orange, over 18 years old and that my business address is 515 N Sycamore, Suite 512, Santa Ana, California 92701. I am not a party to the within action.

On November 4, 2009, I served the foregoing

Rebuttal to SCO's response to the Incorrect Reduction Claim for County of Orange, CSM 05-4282-I-02

on all other parties to this action by placing a true copy of said document in a sealed envelope in the following manner:

[X] (BY U.S. MAIL) I placed such envelope(s) addressed as shown below for collection and mailing at Santa Ana, California, following our ordinary business practices. I am readily familiar with this office's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service in a sealed envelope with postage fully prepaid.

[ ] (BY OVERNIGHT DELIVERY) I placed such envelope(s) addressed as shown below for collection and delivery by UPS with delivery fees paid or provided for in accordance with this office's practice. I am readily familiar with this office's practice for processing correspondence for delivery the following day by UPS.

[ ] (BY FACSIMILE) I caused such document to be telefaxed to the addressee(s) and number(s) shown below, wherein such telefax is transmitted that same day in the ordinary course of business.

[] (BY PERSONAL SERVICE) I caused such envelope(s) to be hand-delivered to the addressee(s) shown below.

[**X**] (STATE) I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

[] (FEDERAL) I declare that I am employed in the office of a member of the Bar of this Court at whose direction the service was made.

Lindsay Chung

Nancy Patton, Asst. Executive Director
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814

Ginny Brummels
Division of Accounting and Reporting
State Controller's Office
3301 C Street, Suite 700
Sacramento, CA 95816

EXHIBIT D

STATE OF CALIFORNIA

EDMUND G. BROWN JR., Governor

COMMISSION ON STATE MANDATES
980 NINTH STREET, SUITE 300
SACRAMENTO, CA 95814
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June 10, 2011

Mr. David Sundstrom
Auditor-Controller
County of Orange
P.O. Box 567
Santa Ana, CA 92702

Mr. Howard Thomas
HCA Claims and Financial Reporting
515 N. Sycamore Street, 5th Floor
Santa Ana, CA 92701

Ms. Jill Kanemasu
Division of Accounting and Reporting
State Controller's Office
3301 C Street, Suite 700
Sacramento, CA 95816

And Interested Parties and Affected State Agencies (See Mailing List)

Re: **Draft Staff Analysis, Schedule for Comments, and Hearing Date**
Incorrect Reduction Claims
Handicapped and Disabled Students, 05-4282-I-02, 09-4282-I-04
County of Orange, Claimant
Statutes 1984, Chapter 1747; Statutes 1985, Chapter 1274
Fiscal Year 1997-1997, 1998-1999, 2000-2001

Dear Mr. Sundstrom, Mr. Thomas, and Ms. Kanemasu:

The draft staff analysis for the above-named incorrect reduction claims is enclosed for your review and comment.

Written Comments

Any party or interested person may file written comments on the draft staff analysis by Friday, **July 1, 2011.** You are advised that comments filed with the Commission are required to be simultaneously served on the other interested parties on the mailing list, and to be accompanied by a proof of service. (Cal. Code Regs., tit. 2, § 1181.2.) However, this requirement may also be satisfied by electronically filing your documents on the Commission's website. Please see the Commission's website at http://www.csm.ca.gov/dropbox_procedures.shtml for instructions on electronic filing. The comments will be posted on the Commission's website and the mailing list will be notified by electronic mail of the posting and the comment period. This procedure will satisfy all the service requirements under section 1181.2(c) or our regulations.

If you would like to request an extension of time to file comments, please refer to section 1183.01(c)(1) of the Commission's regulations.

Hearing

This matter is set for hearing on **Thursday, July 28, 2011**, at 9:30 a.m. in Room 447 of the State Capitol, Sacramento, California. The final staff analysis will be issued on or about July 14, 2011. This matter is proposed for the Consent Calendar. Please let us know in advance

if you or a representative of your agency will testify at the hearing, and if other witnesses will appear. If you would like to request postponement of the hearing, please refer to section 1183.01(c)(2), of the Commission's regulations.

Please contact Camille Shelton at (916) 323-3562 with any questions.

Sincerely,

Drew Bohan
Executive Director

Hearing Date: July 28, 2011
j:\mandates\irc\2005/05-4282-I-02\dsa

ITEM __

INCORRECT REDUCTION CLAIM
DRAFT STAFF ANALYSIS

Government Code Sections 7570-7588

Statutes 1984, Chapter 1747 (AB 3632)
Statutes 1985, Chapter 1274 (AB 882)

California Code of Regulations, Title 2, Sections 60000-60610
(Emergency regulations effective January 1, 1986 [Register 86, No. 1], and re-filed
June 30, 1986, designated effective July 12, 1986 [Register 86, No. 28

Handicapped and Disabled Students
Fiscal Years 1997-1998, 1998-1999, 2000-2001
05-4282-I-02 and 09-4282-I-04

County of Orange, Claimant

EXECUTIVE SUMMARY

Overview

This is an incorrect reduction claim filed by the County of Orange regarding reductions made by the State Controller's Office to reimbursement claims for costs incurred in three fiscal years (1997-1998, 1998-1999, and 2000-2001), in the total amount of $2,676,659 to provide medication monitoring services to seriously emotionally disturbed pupils under the *Handicapped and Disabled Students* program. These incorrect reduction claims are being consolidated because they raise common questions of law and fact.[1]

The *Handicapped and Disabled Students* program was enacted by the Legislature to implement federal law that requires states to guarantee to disabled pupils the right to receive a free and appropriate public education that emphasizes special education and related services, including psychological and other mental health services, designed to meet the pupil's unique educational needs. The program shifted to counties the responsibility and funding to provide mental health services required by a pupil's individualized education plan (IEP).

The State Controller's Office contends that medication monitoring is not a reimbursable activity during the audit period, and did not become reimbursable until fiscal year 2001-2002. The State Controller's Office also argues that the County's first incorrect reduction claim filed for fiscal years 1997-1998 and 1998-1999 was not timely filed.

The County disagrees with the State Controller's Office. The County seeks a determination from the Commission pursuant to Government Code section 17551(d), that the State Controller's

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[1] California Code of Regulations, title 2, section 1185.4.

Office incorrectly reduced the claim, and requests that the Controller reinstate the $2,676,659 reduced for fiscal years 1997-1998 through 2000-2001.

For the reasons below, staff finds the County is not eligible for reimbursement for providing medication monitoring services until July 1, 2001. Thus, the State Controller's Office correctly reduced the County's reimbursement claims for medication monitoring costs incurred in fiscal years 1997-1998, 1998-1999, and 2000-2001.

Procedural History

The Commission received the County's incorrect reduction claim for 1997-1998 and 1998-1999 costs on May 1, 2006, and received the County's incorrect reduction claim for 2000-2001 costs on March 15, 2010. Both claims were issued for comment. The State Controller's Office filed comments addressing the substantive issues on October 6, 2009. The County filed a rebuttal on November 9, 2009.

Staff Analysis

<u>Merits of the incorrect reduction claims</u>

Costs incurred for this program in fiscal years 1997-1998, 1998-1999, and 2000-2001 are eligible for reimbursement under the parameters and guidelines for *Handicapped and Disabled Students* (CSM 4282), which authorize reimbursement for mental health treatment as follows:

> Ten (10) percent of any costs related to mental health treatment services rendered under the Short-Doyle Act:
>
> 1. The scope of the mandate is ten (10) percent reimbursement.
> 2. For each eligible claimant, the following cost items, for the provision of mental health services when required by a child's individualized education program, are ten (10) percent reimbursable (Gov. Code, § 7576):
>   a. Individual therapy;
>   b. Collateral therapy and contacts;
>   c. Group therapy;
>   d. Day treatment; and
>   e. Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.
> 3. Ten (10) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

While the County acknowledges that medication monitoring is not expressly listed as a reimbursable activity in the parameters and guidelines, the County argues that medication monitoring is a reimbursable activity and that the parameters and guidelines authorize reimbursement for "any costs related to mental health treatment services rendered …."

The County's interpretation of the issue, however, conflicts with prior final decisions of the Commission on the issue of medication monitoring.

The Commission has determined that counties are not eligible for reimbursement for providing medication monitoring services until July 1, 2001. The Commission's findings on this issue are bulleted below:

1. The Commission did not approve reimbursement for medication monitoring in the original *Handicapped and Disabled Students* program (CSM 4282) or on reconsideration of that program (04-RL-4282-10). On reconsideration of the *Handicapped and Disabled Students* program (04-RL-4282-10), the Commission stated that "medication monitoring" is part of the new regulatory definition of "mental health services" adopted in 1998. The 1998 regulations were not included in the test claim for *Handicapped and Disabled Students* (CSM 4282). The Commission stated the following:

   > "Medication monitoring" is part of the new, and current, definition of "mental health services" that was adopted by the Departments of Mental Health and Education in 1998. The current definition of "mental health services" and "medication monitoring" is the subject of the pending test claim, *Handicapped and Disabled Students II* (02-TC-40 and 02-TC-49), and will not be specifically analyzed here.

2. The Commission adopted a statement of decision in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) on May 26, 2005, and found that the activity of "medication monitoring," as defined in the 1998 amendment of section 60020, did not simply clarify existing law, but constituted a new program or higher level of service beginning July 1, 2001.

3. In 2006, the Commission considered two requests to amend the parameters and guidelines for the original program in *Handicapped and Disabled Students* (CSM 4282) filed by the Counties of Los Angeles and Stanislaus. (00-PGA-03/04). As part of the requests, the Counties wanted the Commission to apply the 1998 regulations, including the provision of medication monitoring services, to the original parameters and guidelines in *Handicapped and Disabled Students* (CSM 4282). On December 4, 2006, the Commission denied the request, finding that the 1998 regulations were not pled in the original test claim, and cannot by law be applied retroactively to the original parameters and guidelines in *Handicapped and Disabled Students* (CSM 4282).

These decisions of the Commission are final, binding decisions and were never challenged by the parties. Once "the Commission's decisions are final, whether after judicial review or without judicial review, they are binding, just as judicial decisions."[2] Accordingly, based on these decisions, counties are not eligible for reimbursement for medication monitoring until July 1, 2001.

Therefore, the State Controller's Office correctly reduced the reimbursement claims of the County of Orange for costs incurred in fiscal years 1997-1998, 1998-1999, and 2000-2001 to provide medication monitoring services to seriously emotionally disturbed pupils under the *Handicapped and Disabled Students* program.

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[2] *California School Boards Assoc. v. State of California* (2009) 171 Cal.App.4th 1183, 1200.

Statute of limitations issue

Staff further finds the County timely filed the first incorrect reduction claim for the 1997-1998 and 1998-1999 fiscal year costs (05-4282-I-02).

Under the Commission's regulations, an incorrect reduction claim must be filed within three years of the date of the remittance advice or other notice of reduction. A document is timely filed with the Commission if the time for filing has not expired on the date of its mailing by certified or express mail as shown on the postal receipt or postmark.

In this case, the remittance advice is dated April 28, 2003. The County mailed the incorrect reduction claim (05-4282-I-02) by express mail with a postmark of April 28, 2006, three years to the day of the remittance advice. Although the Commission received the filing on May 1, 2006, the claim is considered timely when using the date of the remittance advice. The time for filing had not expired when the claim was deposited in the mail on April 28, 2006.

Conclusion

Staff concludes that the State Controller's Office correctly reduced the County's reimbursement claims for costs incurred in fiscal years 1997-1998, 1998-1999, and 2000-2001, for providing medication monitoring services to seriously emotionally disturbed pupils under the *Handicapped and Disabled Students* program.

Staff Recommendation

Staff recommends that the Commission adopt this analysis and deny the incorrect reduction claims filed by the County of Orange (05-4282-I-02, 09-4282-I-04).

STAFF ANALYSIS

Claimant

County of Orange

Chronology

12/26/2002	State Controller's Office issues audit report for costs incurred in fiscal years 1997-1998 and 1998-1999 by the County of Orange and reduces costs for "medication monitoring" (Audit Finding 1)
04/28/2006	State Controller's Office issues remittance advice to County of Orange
05/01/2006	Commission receives incorrect reduction claim filed by County of Orange for reductions made to fiscal year 1997-1998 and 1998-1999 costs for "medication monitoring" (05-4282-I-02)
05/12/2006	Incorrect reduction claim deemed complete and issued for comment (05-4282-I-02)
03/30/2007	State Controller's Office issues audit report for costs incurred in fiscal year 2000-2001 by the County of Orange and reduces costs for "medication monitoring" (Audit Finding 3)
10/06/2009	State Controller's Office files response to incorrect reduction claim (05-4282-I-02)
11/09/2009	County of Orange files rebuttal (05-4282-I-02)
03/15/2010	County of Orange files incorrect reduction claim for reductions made to fiscal year 2000-2001 costs for "medication monitoring" (09-4282-I-04)
03/17/2010	Incorrect reduction claim deemed complete and issued for comment (09-4282-I-04)

I. Background

This is an incorrect reduction claim filed by the County of Orange for costs incurred in three fiscal years (1997-1998, 1998-1999, and 2000-2001) to provide medication monitoring services to seriously emotionally disturbed pupils under the *Handicapped and Disabled Students* program.[3] The State Controller's Office reduced the County's reimbursement claims in the amount of $2,676,659, arguing that medication monitoring is not a reimbursable activity during the audit period, and did not become reimbursable until fiscal year 2001-2002.

[3] The reduction of costs for medication monitoring for these fiscal years are as follows:

Fiscal year	Amount of Reduction
1997-1998	$ 759,114
1998-1999	$ 870,701
2000-2001	$1,046,844
Total	$2,676,659

The *Handicapped and Disabled Students* program was enacted by the Legislature in 1986 to implement federal law (the Individuals with Disabilities Education Act, IDEA) that requires states to guarantee to disabled pupils the right to receive a free and appropriate public education that emphasizes special education and related services, including psychological and other mental health services, designed to meet the pupil's unique educational needs. The program shifted to counties the responsibility and funding to provide mental health services required by a pupil's individualized education plan (IEP).

The *Handicapped and Disabled Students* program has a long and complicated history. However, the substantive issue presented in this claim relates to the sole issue of whether providing medication monitoring services is reimbursable in fiscal years 1997-1998, 1998-1999, and 2000-2001. As described in the analysis, the Commission has previously addressed the issue of medication monitoring and decisions have been adopted on the issue. These decisions are now final and must be followed here.

II. Positions of the Parties

Position of the State Controller's Office

The State Controller's Office contends that medication monitoring is not a reimbursable activity under the parameters and guidelines in effect during the audited years. The State Controller's Office further argues that the County's incorrect reduction claim filed for the fiscal year 1997-1998 and 1998-1999 costs (05-4282-I-02) was filed after the time required in the Commission's regulations, and should therefore not be considered by the Commission.

Claimant's Position

The County disagrees with the reduction of costs by the State Controller's Office and contends that medication monitoring is a reimbursable activity during the audit period in question. The County argues that the parameters and guidelines state that "any" costs related to the mental health treatment services rendered under the Short-Doyle Act are reimbursable and, while "medication monitoring" is not specifically identified, it is not excluded either. The County asserts that "medication monitoring" has always been part of the treatment services rendered under the Short-Doyle Act. The County further asserts that the Commission clarified this point when it adopted the parameters and guidelines in *Handicapped and Disabled Students II*, specifically listing "medication monitoring" as a reimbursable activity.

The County further argues that its first incorrect reduction claim on this issue (05-4282-I-02) was filed within the statute of limitations.

The County seeks a determination from the Commission pursuant to Government Code section 17551(d), that the State Controller's Office incorrectly reduced the claim, and requests that the Controller reinstate the $2,676,659 reduced for fiscal years 1997-1998, 1998-1999, and 2000-2001.

III. Discussion

Government Code section 17561(b) authorizes the State Controller's Office to audit the claims filed by local agencies and school districts and to reduce any claim for reimbursement of state-mandated costs that the State Controller's Office determines is excessive or unreasonable.

Government Code Section 17551(d) requires the Commission to hear and decide a claim that the State Controller's Office has incorrectly reduced payments to the local agency or school district. That section states the following:

> The commission, pursuant to the provisions of this chapter, shall hear and decide upon a claim by a local agency or school district filed on or after January 1, 1985, that the Controller has incorrectly reduced payments to the local agency or school district pursuant to paragraph (2) of subdivision (b) of Section 17561.

If the Commission determines that a reimbursement claim has been incorrectly reduced, section 1185.7 of the Commission's regulations requires the Commission to send the statement of decision to the State Controller's Office and request that the costs in the claim be reinstated.

A. The State Controller's Office correctly reduced the County's reimbursement claims for the costs incurred to provide medication monitoring services in fiscal years 1997-1998, 1998-1999, and 2000-2001.

Costs incurred for this program in fiscal years 1997-1998, 1998-1999, and 2000-2001 are eligible for reimbursement under the parameters and guidelines for *Handicapped and Disabled Students* (CSM 4282). The test claim in *Handicapped and Disabled Students* was filed on Government Code section 7570 et seq., as added and amended by Statutes 1984 and 1985, and on the initial emergency regulations adopted in 1986 by the Departments of Mental Health and Education to implement this program.[4] In 1990 and 1991, the Commission approved the test claim and adopted parameters and guidelines, authorizing reimbursement for mental health treatment services as follows:

> Ten (10) percent of any costs related to mental health treatment services rendered under the Short-Doyle Act:
>
> 1. The scope of the mandate is ten (10) percent reimbursement.
> 2. For each eligible claimant, the following cost items, for the provision of mental health services when required by a child's individualized education program, are ten (10) percent reimbursable (Gov. Code, § 7576):
>   a. Individual therapy;
>   b. Collateral therapy and contacts;
>   c. Group therapy;
>   d. Day treatment; and
>   e. Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.
> 3. Ten (10) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

[4] California Code of Regulations, title 2, division 9, sections 60000-60610 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and re-filed June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)).

While the County acknowledges that medication monitoring is not expressly listed as a reimbursable activity in the parameters and guidelines, the County argues that medication monitoring is a reimbursable activity and that the parameters and guidelines authorize reimbursement for "any costs related to mental health treatment services rendered …."

The County's interpretation of the issue, however, conflicts with prior final decisions of the Commission on the issue of medication monitoring.

The *Handicapped and Disabled Students* (CSM 4282) decision addressed Government Code section 7576 and the implementing regulations as they were originally adopted in 1986. Government Code section 7576 required the county to provide psychotherapy or other mental health services when required by a pupil's IEP. Former section 60020 of the Title 2 regulations defined "mental health services" to include the day services and outpatient services identified in sections 542 and 543 of the Department of Mental Health's Title 9 regulations. (Former Cal. Code Regs., tit. 2, § 60020(a).) Section 543 defined outpatient services to include "medication." "Medication" was defined to include "prescribing, administration, or dispensing of medications necessary to maintain individual psychiatric stability during the treatment process," and "shall include the evaluation of side effects and results of medication."

In 2004, the Commission was directed by the Legislature to reconsider its decision in *Handicapped and Disabled Students*. On reconsideration of the program in *Handicapped and Disabled Students* (04-RL-4282-10), the Commission found that the phrase "medication monitoring" was not included in the original test claim legislation. "Medication monitoring" was added to the regulations for this program in 1998 (Cal. Code Regs. tit. 2, § 60020). The Commission determined that:

> "Medication monitoring" is part of the new, and current, definition of "mental health services" that was adopted by the Departments of Mental Health and Education in 1998. The current definition of "mental health services" and "medication monitoring" is the subject of the pending test claim, *Handicapped and Disabled Students II* (02-TC-40 and 02-TC-49), and will not be specifically analyzed here.[5]

Thus, the Commission did not approve reimbursement for medication monitoring in *Handicapped and Disabled Students* (CSM 4282) or on reconsideration of that program (04-RL-4282-10).

The 1998 regulations were pled in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), however. *Handicapped and Disabled Students II* was filed in 2003 on subsequent statutory and regulatory changes to the program, including the 1998 amendments to the regulation that defined "mental health services." On May 26, 2005, the Commission adopted a statement of decision finding that the activity of "medication monitoring," as defined in the 1998 amendment of section 60020, constituted a new program or higher level of service *beginning July 1, 2001*. The Commission's decision in *Handicapped and Disabled Students II* states the following:

[5] Statement of decision, Reconsideration of Handicapped and Disabled Students (04-RL-4282-10), page 42.

The Department of Finance argues that "medication monitoring" does not increase the level of service provided by counties. The Department states the following:

> It is our interpretation that there is no meaningful difference between the medication requirements under the prior regulations and the new regulations of the test claim. The existing activities of "dispensing of medications, and the evaluation of side effects and results of medication" are in fact activities of medication monitoring and seem representative of all aspects of medication monitoring. To the extent that counties are already required to evaluate the "side effects and results of medication," it is not clear that the new requirement of "medication monitoring" imposes a new or higher level of service. [footnote omitted.]

The Commission disagrees with the Department's interpretation of section 60020, subdivisions (i) and (f), of the regulations, and finds that "medication monitoring" as defined in the regulation increases the level of service required of counties.

The same rules of construction applicable to statutes govern the interpretation of administrative regulations. [Footnote omitted.] Under the rules of statutory construction, it is presumed that the Legislature or the administrative agency intends to change the meaning of a law or regulation when it materially alters the language used. [Footnote omitted.] The courts will not infer that the intent was only to clarify the law when a statute or regulation is amended unless the nature of the amendment clearly demonstrates the case. [Footnote omitted.]

In the present case, the test claim regulations, as replaced in 1998, materially altered the language regarding the provision of medication. The activity of "dispensing" medications was deleted from the definition of mental health services. In addition, the test claim regulations deleted the phrase "evaluating the side effects and results of the medication," and replaced the phrase with "monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness." The definitions of "evaluating" and "monitoring" are different. To "evaluate" means to "to examine carefully; appraise."[6] To "monitor" means to "to keep watch over; supervise."[7] The definition of "monitor" and the regulatory language to monitor the "psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness" indicate that the activity of "monitoring" is an ongoing activity necessary to ensure that the pupil receives a free and appropriate education under federal law. This interpretation is supported by the final statement of reasons for the adoption of the language in section 60020, subdivision (f), which state that the regulation was intended to make it clear that "medication monitoring" is an educational service

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[6] Webster's II New College Dictionary (1999) page 388.

[7] *Id.* at page 708.

that is provided pursuant to an IEP, rather than a medical service that is not allowable under the program.[8]

> Neither the Department of Mental Health nor the Department of Education, agencies that adopted the regulations, filed substantive comments on this test claim. Thus, there is no evidence in the record to contradict the finding, based on the rules of statutory construction, that "medication monitoring" increases the level of service on counties.
>
> Therefore, the Commission finds that the activity of "medication monitoring," as defined in section 60020, subdivisions (f) and (i), constitutes a new program or higher level of service.[9]

In 2001, the Counties of Los Angeles and Stanislaus filed separate requests to amend the parameters and guidelines for the original program in *Handicapped and Disabled Students* (CSM 4282). As part of the requests, the Counties wanted the Commission to apply the 1998 regulations, including the provision of medication monitoring services, to the original parameters and guidelines. On December 4, 2006, the Commission denied the request, finding that the 1998 regulations were not pled in original test claim, and cannot by law be applied retroactively to the original parameters and guidelines in *Handicapped and Disabled Students* (CSM 4282). The analysis adopted by the Commission on the issue states the following:

> The counties request that the Commission amend the provision in the parameters and guidelines for mental health services to include the current regulatory definition of "mental health services," medication monitoring, and crisis intervention. The counties request the following language be added to the parameters and guidelines:
>
> > For each eligible claimant, the following cost items, for the provision of services when required by a child's individualized education program in accordance with Section 7572(d) of the Government Code: psychotherapy (including outpatient crisis-intervention psychotherapy provided in the normal course of IEP services when a pupil exhibits acute psychiatric symptoms, which, if untreated, presents an imminent threat to the pupil) as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management are reimbursable (Government Code 7576). "Medication monitoring" includes medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. [Footnote omitted.]

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[8] Final Statement of Reasons, page 7.

[9] Statement of decision, *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), pages 37-39.

> The counties' proposed language, however, is based on regulations amended by the Departments of Mental Health and Education effective July 1, 1998. (Cal. Code Regs., tit. 2, § 60020, subds. (i) and (f).) The 1998 regulations were considered by the Commission in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), and approved for the following activities beginning July 1, 2001:
>
> - Provide individual or group psychotherapy services, as defined in Business and Professions Code section 2903, when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
> - Provide medication monitoring services when required by the pupil's IEP. "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subds. (f) and (i).)
>
> The Commission's findings in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), approving reimbursement for medication monitoring and psychotherapy services as currently defined in the regulations were not included in the original test claim (CSM 4282) and, thus, cannot be applied retroactively to the original parameters and guidelines. Based on Government Code section 17557, subdivision (e), the reimbursement period for the activities approved by the Commission in *Handicapped and Disabled II* begins July 1, 2001.
>
> Therefore, the proposed amendment to add language based on the current definition of "mental health services," including medication monitoring, is inconsistent with, and not supported by the Commission's original 1990 Statement of Decision in *Handicapped and Disabled Students* (CSM 4282).[10]

These decisions of the Commission are final, binding decisions and were never challenged by the parties. Once "the Commission's decisions are final, whether after judicial review or without judicial review, they are binding, just as judicial decisions."[11] Accordingly, based on these decisions, counties are not eligible for reimbursement for medication monitoring until July 1, 2001.

Therefore, the State Controller's Office correctly reduced the reimbursement claims of the County of Orange for costs incurred in fiscal years 1997-1998, 1998-1999, and 2000-2001 to provide medication monitoring services to seriously emotionally disturbed pupils under the *Handicapped and Disabled Students* program.

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[10] Analysis adopted by Commission on December 4, 2006, in 00-PGA-03/04.

[11] *California School Boards Assoc. v. State of California (*2009) 171 Cal.App.4th 1183, 1200.

B. **The County's first incorrect reduction claim (05-4282-I-02) was filed within the time required by the Commission's regulations and, thus, the Commission has jurisdiction to determine the claim.**

The State Controller's Office argues that the County failed to file the incorrect reduction claim for fiscal years 1997-1998 and 1998-1999 (05-4282-I-02) within the time required by the Commission's regulations. The Controller's Office states the following:

> Section 1185, subdivision (b) states that "[a]ll incorrect reduction claims shall be filed with the commission no later than three (3) years following the date of the Office of State Controller's remittance advice or other notice of adjustment notifying the claimant of a reduction." In this case, the remittance advice and accompanying letter were dated April 28, 2003 (See pages 2-5 of Exhibit C of the Claimant's IRC). Therefore, the last date to file an IRC was April 28, 2003. However, the Claimant did not file its claim until May 1, 2003, outside the time frame provided, and thus, the IRC is precluded by the limitations provision of Section 1185.

Using the date of the remittance advice, the County's filing is timely. Section 1181.1(g) of the Commission's regulations defines "filing date" as follows:

> . . . the date of delivery to the commission office during normal business hours. For purposes of meeting the filing deadlines required by statute, the filing is timely if:
>
> (1) The filing is submitted by certified or express mail or a common carrier promising overnight delivery, and
>
> (2) The time for its filing had not expired on the date of its mailing by certified or express mail as shown on the postal receipt or postmark, or the date of its delivery to a common carrier promising overnight deliver as shown on the carrier's receipt.

Section 1181.2 further states that "service by mail is complete when the document is deposited in the mail."

In this case, the County mailed the incorrect reduction claim (05-4282-I-02) by express mail with a postmark of April 28, 2006, three years to the day of the remittance advice. Although the Commission received the filing on May 1, 2006, the claim would still be considered timely, when using the date of the remittance advice. The time for filing had not expired when the claim was deposited in the mail on April 28, 2006.

However, at the time the County filed its incorrect reduction claim, section 1185 of the Commission's regulations provided that the three year deadline to file an incorrect reduction claim starts to run from "the date of the Office of State Controller's remittance advice *or other notice of adjustment notifying the claimant of a reduction*." The audit report for the County's reimbursement claims filed for fiscal years 1997-1998 and 1998-1999 identifies the Controller's intention to reduce the County's claims for medication monitoring and is dated December 26, 2002, four months earlier than the remittance advice. Three years from the date of the audit report would be December 26, 2005 (more than four months before the County filed its claim).

The Controller's Office does not base its statute of limitations argument on the date of the audit report, however. Moreover, section 1185 of the Commission's regulations does not require the running of the time period from when a claimant *first* receives notice; but simply states that the time runs from either the remittance advice *or* other notice of adjustment.

Thus, when viewed in a light most favorable to the County, and based on the policy determined by the courts favoring the disposition of cases on their merits rather than on procedural grounds,[12] staff finds that the County timely filed the incorrect reduction claim for the fiscal year 1997-1998 and 1998-1999 costs.

IV. Conclusion

Staff concludes that the State Controller's Office correctly reduced the County's reimbursement claims for costs incurred in fiscal years 1997-1998, 1998-1999, and 2000-2001, for providing medication monitoring services to seriously emotionally disturbed pupils under the *Handicapped and Disabled Students* program.

V. Staff Recommendation

Staff recommends that the Commission adopt this analysis and deny the incorrect reduction claims filed by the County of Orange (05-4282-I-02, 09-4282-I-04).

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[12] *O'Riordan v. Federal Kemper Life Assurance* (2005) 36 Cal.4th 281, 284; *California Department of Corrections and Rehabilitation v. State Personnel Board* (2007) 147 Cal.App.4th 797, 805.

Commission on State Mandates

Original List Date:
Last Updated: 6/10/2011
List Print Date: 06/10/2011
Claim Number: 05-4282-I-02,09-4282-I-04
Issue: Handicapped and Disabled Students

Mailing List

TO ALL PARTIES AND INTERESTED PARTIES:

Each commission mailing list is continuously updated as requests are received to include or remove any party or person on the mailing list. A current mailing list is provided with commission correspondence, and a copy of the current mailing list is available upon request at any time. Except as provided otherwise by commission rule, when a party or interested party files any written material with the commission concerning a claim, it shall simultaneously serve a copy of the written material on the parties and interested parties to the claim identified on the mailing list provided by the commission. (Cal. Code Regs., tit. 2, § 1181.2.)

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C

Court of Appeal, Fifth District, California.
CALIFORNIA DEPARTMENT OF CORRECTIONS and REHABILITATION, Plaintiff and Respondent,
v.
CALIFORNIA STATE PERSONNEL BOARD, Defendant and Respondent.
Darrell Snell et al., Real Parties in Interest and Appellants.

No. F048806.
Feb. 14, 2007.

Background: Disciplinary actions were brought against employees of the California Department of Corrections (CDC), based upon their dishonest denials of underlying charges that had been **barred** by **statute** of **limitations**. State Personnel Board dismissed all charges, including the charges of dishonesty. CDC filed a petition for a writ of administrative mandamus. The Superior **Court**, Fresno County, No. 03CECG02539, Rosendo Pena, J., ordered the dishonesty charges reinstated. Employees appealed.

Holding: The **Court** of Appeal, Ardaiz, P. J., held that **statute** of **limitations** did **not bar** disciplinary actions against employees based upon their dishonest denials of underlying charges that were **barred** by **statute** of **limitations**.

Affirmed.

West Headnotes

[1] Administrative Law and Procedure 15A ⚷796

15A Administrative Law and Procedure
15AV Judicial Review of Administrative Decisions
15AV(E) Particular Questions, Review of
15Ak796 k. Law questions in general. Most Cited Cases

Where the facts in administrative proceedings are undisputed, the administrative review board's ultimate conclusion is a pure question of law subject to de novo review.

[2] Appeal and Error 30 ⚷842(1)

30 Appeal and Error
30XVI Review
30XVI(A) Scope, Standards, and Extent, in General
30k838 Questions Considered
30k842 Review Dependent on Whether Questions Are of Law or of Fact
30k842(1) k. In general. Most Cited Cases

Officers and Public Employees 283 ⚷72.51

283 Officers and Public Employees
283I Appointment, Qualification, and Tenure
283I(H) Proceedings for Removal, Suspension, or Other Discipline
283I(H)3 Judicial Review
283k72.49 Scope of Review
283k72.51 k. Trial or hearing de novo. Most Cited Cases

Court of Appeal is not bound by the State Personnel Board's or the trial court's application and interpretation of a statute.

[3] Officers and Public Employees 283 ⚷72.12

283 Officers and Public Employees
283I Appointment, Qualification, and Tenure
283I(H) Proceedings for Removal, Suspension, or Other Discipline
283I(H)1 In General
283k72.11 Notice or Charge
283k72.12 k. In general. Most Cited Cases

Statute of **limitations** that applied to adverse actions against state employees of California Department of Corrections (CDC) did **not bar** disciplinary actions against employees based upon their dishonest

denials of underlying charges that were **barred** by **statute** of **limitations**; consistent with plain language of **statute** of **limitations** and public policy considerations, extensive lying during the course of investigative interviews that occurred within the applicable **statute** of **limitations** of the matter being investigated did **not** merge with the underlying offenses. West's Ann.Cal.Gov. Code § 19635.
See 3 Witkin, Cal. Procedure (4th ed. 1996) Actions, § 405 et seq.; Cal. Jur. 3d, Limitation of Actions, § 125 et seq.

[4] Statutes 361 ⚷181(1)

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k180 Intention of Legislature
361k181 In General
361k181(1) k. In general. Most Cited Cases

Statutes 361 ⚷184

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k180 Intention of Legislature
361k184 k. Policy and purpose of act. Most Cited Cases

When interpreting a statute, courts must ascertain legislative intent so as to effectuate the law's purpose.

[5] Constitutional Law 92 ⚷2473

92 Constitutional Law
92XX Separation of Powers
92XX(C) Judicial Powers and Functions
92XX(C)2 Encroachment on Legislature
92k2472 Making, Interpretation, and Application of Statutes
92k2473 k. In general. Most Cited Cases
(Formerly 92k70.1(2))

Statutes 361 ⚷176

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k176 k. Judicial authority and duty. Most Cited Cases

Statutes 361 ⚷186

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k180 Intention of Legislature
361k186 k. Cases and matters omitted. Most Cited Cases

In the construction of a statute the office of the judge is simply to ascertain and declare what is contained therein, not to insert what has been omitted, or to omit what has been inserted.

[6] Statutes 361 ⚷188

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k187 Meaning of Language
361k188 k. In general. Most Cited Cases

Statutes 361 ⚷190

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k187 Meaning of Language
361k190 k. Existence of ambiguity. Most Cited Cases

Statutes 361 ⚷205

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k204 Statute as a Whole, and Intrinsic Aids to Construction
361k205 k. In general. Most Cited Cases

Legislative intent will be determined so far as possible from the language of statutes, read as a whole, and if the words are reasonably free from ambiguity and uncertainty, the courts will look no further to ascertain its meaning.

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[7] Statutes 361 174

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k174 k. In general. Most Cited Cases

When construing a statute, the court should take into account matters such as context, the object in view, the evils to be remedied, the history of the times and of legislation upon the same subject, public policy, and contemporaneous construction.

[8] Statutes 361 208

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k204 Statute as a Whole, and Intrinsic Aids to Construction
361k208 k. Context and related clauses. Most Cited Cases

When construing a statute, the various parts of the enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole.

[9] Limitation of Actions 241 1

241 Limitation of Actions
241I **Statutes** of **Limitation**
241I(A) Nature, Validity, and Construction in General
241k1 k. Nature of statutory limitation. Most Cited Cases

There are several policies underlying **statutes** of **limitation**; one purpose is to give defendants reasonable repose, thereby protecting parties from defending stale claims, and such statutes also stimulate **plaintiffs** to pursue their claims diligently.

[10] Limitation of Actions 241 1

241 Limitation of Actions
241I **Statutes** of **Limitation**
241I(A) Nature, Validity, and Construction in General
241k1 k. Nature of statutory limitation. Most Cited Cases

A countervailing factor to those factors justifying **statutes** of **limitation**, is the policy **favoring** disposition of cases on the **merits** rather than on procedural grounds.

** Wendell J. Llopis, for Real Parties in Interest and Appellants.

No appearance for Defendant and Respondent.

K. William Curtis, Warren C. Stracener, Wendi L. Ross, and Christopher E. Thomas, for **Plaintiff** and Respondent.

*** OPINION**

ARDAIZ, P.J.

INTRODUCTION

In a case of first impression, we are asked to determine whether Government Code section 19635 [FN1] **bars** disciplinary actions against employees of the California Department of Corrections (CDC) [FN2] based upon their dishonest denials of underlying charges where the underlying charges are **barred** by section 19635. We do **not** find ** that extensive lying during the course of investigative interviews that occurred within the applicable **statute** of **limitations** of the matter being investigated merges with the underlying offense. This is consistent with case law saying that dishonesty is a separate act. Thus, section 19635 does **not bar** the disciplinary actions in this case.

FN1. All section citations are from the Government Code, unless otherwise stated.

FN2. CRC is currently known as the California Department of Corrections and Rehabilitation. For the purposes of consistency with the prior case history, we will continue to refer to it as CRC.

STATEMENT OF THE CASE

The facts are undisputed. Darrell Snell (Snell), Wayne Villarreal (W. Villarreal), Stephanie Rodriguez (Rodriguez), and Rene Villarreal (R. Villarreal), are employees of CDC. Snell and W. Villarreal are peace officer employees, and Rodriguez and R. Villarreal are civilian employees.

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***800** Pursuant to section 19574, subdivision (a), CDC served various written notices of adverse actions (Notices) imposing disciplinary sanctions upon Snell, W. Villarreal, Rodriguez and R. Villarreal for participating in a pyramid scheme from approximately June of 1996 to September of 1996. Snell and W. Villarreal were suspended for 180 work days, Rodriguez was suspended for 120 work days, and R. Villarreal was suspended for 140 work days.

The Notices alleged various causes for discipline based upon the appellants' participation in the pyramid scheme. These causes included section 19572, subdivision (d)—inexcusable neglect of duty; section 19572, subdivision (r)—incompatible activities; and section 19572, subdivision (t)—other failure of good behavior.

The Notices also alleged section 19572, subdivision (f)—dishonesty, as a cause of discipline. CDC alleged that the appellants were dishonest at various investigative interviews conducted by CDC, in calendar years 1997 and 1998, when they denied any participation in the pyramid scheme.

As alleged in the Notice, Snell was interviewed on August 8, 1997 as a witness. He denied any involvement and firsthand knowledge of the pyramid scheme. He participated in an investigatory interview on December 30, 1997. At this second interview, he denied any involvement in the pyramid scheme.

W. Villarreal was interviewed on December 30, 1997. He denied that he was ever approached or recruited into the pyramid scheme. He denied that he was familiar with the pyramid scheme, or had any knowledge of the pyramid scheme other than through rumors. He denied ever attending any pyramid scheme meeting. He further denied discussing or recruiting for the pyramid scheme on the job. He denied that he conducted or hosted pyramid scheme parties or meetings at his home. He denied that he handled monies relative to the pyramid scheme. Although he was advised that several persons had testified that he was actively involved in the pyramid scheme, and had stated that they had been at his home for recruiting parties for the pyramid scheme, W. Villarreal continued to deny any firsthand knowledge of the pyramid scheme or involvement in it at any level.

Rodriguez was interviewed on November 25, 1997. She denied any involvement in the pyramid scheme including ever being approached, recruiting, investing, attending a meeting during which the pyramid scheme was explained and hosting a pyramid scheme party at her home.

R. Villarreal was interviewed on February 11, 1998. During this interview, she denied all involvement and first hand knowledge of the pyramid scheme. She denied investing in the pyramid scheme. She denied recruiting for the ***801** pyramid scheme. She denied attending or hosting any pyramid scheme parties. She denied ****668** ever having received or handled monies for the pyramid scheme.

Snell was served with a notice on December 14, 1999. W. Villarreal was served with a notice on December 15, 1999. Rodriguez was served with a notice on December 2, 1999, and R. Villarreal was served with a notice on December 13, 1999.

Pursuant to section 19575, subdivision (a), the appellants filed timely appeals with the State Personnel Board ("SPB") requesting an administrative hearing to contest the validity of the Notices. The four appeals were consolidated for hearing.

An administrative hearing was held before a duly appointed Administrative Law Judge ("ALJ"). Appellants repeated their denials at the hearing. The ALJ issued proposed decisions sustaining all disciplinary causes of action contained in the Notices, but modified the imposed suspensions. The ALJ found that Snell's and Rodriguez's denials of involvement in the pyramid scheme were not credible in light of testimony by numerous witnesses. The ALJ found that W. Villarreal and R. Villarreal were dishonest when they denied any knowledge of, or participation in, the pyramid scheme. On July 11, 2001, SPB adopted the proposed decisions of the ALJ, but further modified the imposed suspensions.

The appellants filed a timely Petition for Rehearing with SPB pursuant to section 19568. SPB granted appellants' Petition for Rehearing and set the appeals for further hearing and argument.

On August 6, 2002, SPB issued a final decision dismissing all charges contained in the Notices, including the charges of dishonesty. SPB found that the

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Notices were not served within the three-year limitation period of section 19635, and that the facts did not warrant a finding that CDC was entitled to the fraud discovery exception of that statute. SPB held that dishonesty during an investigatory interview is "a separate and serious charge," but that the dishonesty charges were also untimely. SPB found persuasive appellants' argument that to allow the charges of dishonesty, based upon the appellants' denials of participating in the pyramid scheme, to survive the dismissal of the underlying charges "would defeat the purposes of the statute of limitations set forth in Section 19635."

SPB reasoned that for CDC to prove the appellants' denials to be false and dishonest, CDC must prove the appellants' participation in the pyramid scheme to be factually true. SPB held that such a result would force the ***802** appellants to litigate and defend matters whose litigation is already barred by the statute of limitations. According to SPB, "[t]his 'bootstrapping' of the dishonesty charges to the underlying charges would, in turn, serve to eviscerate one of the primary purposes of a statute of limitations—to prevent the hardship and injustice of having to defend against stale claims after memories have faded or evidence has been lost."

On July 11, 2003, CDC filed a Petition for Writ of Administrative Mandamus seeking to set aside SPB's final decision. CDC's Petition was heard on May 13, 2005, before the Honorable Rosendo Pena of the Fresno County Superior Court.

On July 5, 2005, Judge Pena held that SPB correctly decided that all disciplinary charges related to the employees' participation in the pyramid scheme are properly barred by the statute of limitations of section 19635, and that CDC is not entitled to the fraud discovery exception to that statute. However, Judge Pena also held that SPB erred as a matter of law when it dismissed the dishonesty charges as untimely. The trial court ordered the dishonesty****669** charges reinstated against appellants.

Appellants filed a timely Notice of Appeal on September 6, 2005. They appeal only from Judge Pena's decision holding that the dishonesty charges were not barred by section 19635.

DISCUSSION

I. Standard of Review

[1][2] Neither the appellants nor the respondent contest the factual determinations made by the trial court, or those made by SPB. Where the facts are undisputed, SPB's ultimate conclusion is a pure question of law subject to de novo review. (*Moosa v. State Personnel Bd.* (2002) 102 Cal.App.4th 1379, 1384, 126 Cal.Rptr.2d 321, 325.) Furthermore, we are not bound by SPB's or the trial court's application and interpretation of a statute. (*Burden v. Snowden* (1992) 2 Cal.4th 556, 562, 7 Cal.Rptr.2d 531, 535.)

II. *Alameida v. State Personnel Board*

[3] Appellants argue that section 19635 bars the dishonesty charges against them. According to appellants, the dishonesty charges are based upon lies that ***803** merged with, or are derivative of, the underlying misconduct. Given that section 19635 bars charges based upon the underlying misconduct where appellants argue that section 19635 also bars charges based upon lies that merge with, or are derivative, of the underlying misconduct. In support, appellants cite *Alameida v. State Personnel Bd.* (2004) 120 Cal.App.4th 46, 15 Cal.Rptr.3d 383 (*Alameida*).

Alameida involved the interpretation of section 3304, subdivision (d). FN3 In *Alameida,* the "CDC sought to dismiss an employee ... Nathan A. Lomeli, for immorality, discourteous treatment of the public, failure of good behavior, and dishonesty during interviews investigating these charges." (*Alameida, supra,* 120 Cal.App.4th at p. 50, 15 Cal.Rptr.3d 383.) Lomeli allegedly committed sexual offenses on September 18, 1998, and lied about them by falsely denying them in an interview conducted by CDC on July 12, 2000. (*Id.* at p. 51, 15 Cal.Rptr.3d 383.) Lomeli was served with a Notice of Adverse Action on November 15, 2000. (*Ibid.*) Lomeli opposed the adverse employment action, and an administrative hearing was held before an ALJ. (*Ibid.*)

FN3. Section 3304, subdivision (d) provides in relevant part that: "[N]o punitive action, nor denial of promotion on grounds other than merit, shall be undertaken for any act, omission, or other allegation of misconduct if the investigation of the allegation is not completed within one year of the public agency's discovery by a person authorized to

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> initiate an investigation of the allegation of an act, omission, or other misconduct. This one-year limitation period shall apply only if the act, omission, or other misconduct occurred on or after January 1, 1998."

"Although the November 15, 2000, Notice of Adverse Action was served less than one year after Lomeli's alleged dishonesty in denying the sex offenses during the investigatory interview on July 12, 2000, the ALJ determined the dishonesty charge could not survive as a separate basis for discipline, because it flowed directly from the investigation of the September 1998 sex offense, and it would defeat the purpose of [the Public Safety Officers Procedural Bill of Rights Act (§ 3300 *et seq.*) (the Act)] to allow the employer to circumvent the one-year limitations period by allowing the agency to prove the underlying charges in order to demonstrate the employee was dishonest ****670** in denying the charges." (*Alameida, supra,* 120 Cal.App.4th at pp. 51–52, 15 Cal.Rptr.3d 383.) SPB adopted the ALJ's decision. (*Id.* at p. 52, 15 Cal.Rptr.3d 383.)

CDC sought a writ of administrative mandamus, and was denied. The *Alameida* court affirmed. It rejected CDC's argument that the one-year statute of limitations in section 3304, subdivision (d) was extended pursuant to section 3304, subdivision (g), which provides an extension where CDC reopens an investigation based upon significantly new evidence that resulted from the public safety officer's predisciplinary response. (*Alameida, supra,* 120 Cal.App.4th at pp. 60–61, 15 Cal.Rptr.3d 383.)

***804** The *Alameida* court went on to note that "peace officers in interrogations under the Act do not have a right to remain silent." (*Id.* at p. 62, 15 Cal.Rptr.3d 383.) It cited the California Supreme Court case of (*Lybarger v. City of Los Angeles* (1985) 40 Cal.3d 822, 827, 221 Cal.Rptr. 529, 531–32) in which our Supreme Court held that "[a]s a matter of constitutional law, it is well established that a public employee has no absolute right to refuse to answer potentially incriminating questions posed by his employer. Instead, his self-incrimination rights are deemed adequately protected by precluding any use of his statements at a subsequent criminal proceeding." Furthermore, "although the officer under investigation is not compelled to respond to potentially incriminating questions, and his refusal to speak cannot be used against him *in a criminal proceeding,* nevertheless such refusal may be deemed insubordination leading to punitive action by his employer." (*Lybarger v. City of Los Angeles, supra,* 40 Cal.3d at p. 828, 221 Cal.Rptr. 529, 710 P.2d 329.)

Drawing upon this precedent, the *Alameida* court stated that "[i]t is unseemly to force a person to answer an allegation of misconduct and then punish him for denying the allegation." (*Alameida, supra,* 120 Cal.App.4th at p. 62, 15 Cal.Rptr.3d 383, fn. omitted.) The *Alameida* court also agreed "with the ALJ and the trial court that the denial in these circumstances does not constitute separate actionable misconduct but in effect merges with or is derivative of the alleged underlying misconduct. As phrased by the ALJ, the dishonesty charge flows directly from the investigation of the assault. To allow the dishonesty charge to survive would defeat the purpose of the limitations period, which is to ensure that conduct that could result in discipline should be adjudicated when memories are fresh." (*Alameida, supra,* 120 Cal.App.4th at p. 62, 15 Cal.Rptr.3d 383.) [FN4]

> FN4. SPB also was concerned that the " 'bootstrapping' of the dishonesty charges to the underlying charges would, in turn, serve to eviscerate one of the primary purposes of a statute of limitations—to prevent the hardship and injustice of having to defend against stale claims after memories have faded or evidence has been lost."

Although appellants concede that section 3304, subdivision (d) is not the applicable statute of limitations in this case,[FN5] nevertheless, appellants argue that the holding of the *Alameida* court—that a denial of underlying charges merges with the underlying offenses—can be generalized to ****671** all statutes of limitations, including section 19635. We disagree. There is nothing in the plain language of section 19635, or in the purposes of statutes of limitations, that supports a finding that extensive lying during investigatory interviews ***805** merges with the underlying misconduct that is being investigated. Thus, we do not interpret section 19635 to bar the dishonesty charges here.

> FN5. Section 3304, subdivision (d) does not apply in this case for several reasons. First, Snell and W. Villarreal are the only public

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safety officers in this appeal, and section 3304, subdivision (d) only applies to public safety officers. (§ 3301.) Second, their dishonesty occurred during interviews on December 30, 1997, and so was not within the purview of section 3304, subdivision (d), which only applies to misconduct occurring on or after January 1, 1998.

III.
Interpreting Statutes of Limitations

[4][5][6][7][8] "The principles governing the proper construction of a statute are well established...." (*California Teachers Assn. v. Governing Bd. of Golden Valley Unified School Dist.* (2002) 98 Cal.App.4th 369, 375, 119 Cal.Rptr.2d 642, 646.) " 'Courts must ascertain legislative intent so as to effectuate a law's purpose. [Citations.] "In the construction of a statute ... the office of the judge is simply to ascertain and declare what is ... contained therein, not to insert what has been omitted, or to omit what has been inserted; ..." [Citation.] Legislative intent will be determined so far as possible from the language of statutes, read as a whole, and if the words are reasonably free from ambiguity and uncertainty, the courts will look no further to ascertain its meaning. [Citation.] " 'The court should take into account matters such as *context,* the object in view, the evils to be remedied, the history of the times and of *legislation upon the same subject,* public policy, and contemporaneous construction.' " [Citations.] "Moreover, the various parts of a statutory enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole." [Citations.]' " (*Id.* at pp. 375–376, 119 Cal.Rptr.2d 642.)

[9][10] With respect to statutes of limitations, our Supreme Court has held that "[t]here are several policies underlying such statutes. One purpose is to give defendants reasonable repose, thereby protecting parties from 'defending stale claims, where factual obscurity through the loss of time, memory or supporting documentation may present unfair handicaps.' [Citations.] A **statute of limitations** also stimulates **plaintiffs** to pursue their claims diligently. [Citations.] A countervailing factor, of course, is the policy **favoring** disposition of cases on the **merits** rather than on procedural grounds. [Citations.]" (*Fox v. Ethicon Endo–Surgery, Inc.* (2005) 35 Cal.4th 797, 806, 27 Cal.Rptr.3d 661, 666–67.)

Thus, we interpret section 19635 by examining its plain language and in **light** of its purposes.

A.
Section 19635

Section 19635 states:

"No adverse action shall be valid against any state employee for any cause for discipline based on any civil service law of this ***806** state, unless notice of the adverse action is served within three years after the cause for discipline, upon which the notice is based, first arose. Adverse action based on fraud, embezzlement, or the falsification of records shall be valid, if notice of the adverse action is served within three years after the discovery of the fraud, embezzlement, or falsification."

By its plain language, section 19635 provides that disciplinary action can be imposed on a state employee only if the employee was timely served with written notice of the disciplinary action. The written notice must be served upon the state employee within three years after the ****672** cause for discipline first arose, or three years after discovery of fraud, embezzlement, or falsification. (§ 19635.) Moreover, the disciplinary action must be based upon a civil service law of California, or based upon fraud, embezzlement or the falsification of records. (*Ibid.*)

Dishonesty is specifically listed as a cause for discipline in the California civil service law. (§ 19572, subd. (f).) Thus, section 19635 applies to any adverse action based upon dishonesty.

Here, appellants were served with Notices containing dishonesty charges within three years of their dishonest denials at investigatory interviews. Thus, under the plain language of section 19635, appellants could be disciplined for their lies.

B.
The Purpose of Statutes of Limitations Does No Support Barring The Disciplinary Charges

Although appellants concede that dishonesty is categorized as a separate charge under section 19572, they argue that this does **not** mean that "dishonesty is a separately actionable cause for discipline in the context of the **statute of limitations** issue presented in

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this appeal." Appellants contend that section 19635 should be interpreted to **bar** the dishonesty charges because, here, their lies at the investigatory interviews merged with the underlying misconduct being investigated. According to appellants, to interpret section 19635 otherwise would eviscerate the purposes of **statutes** of **limitations**. We disagree.

Lying is a separate and distinct offense from the underlying offense. (§ 19572, subd. (f); *Timothy Welch* (1992) SPB Dec. No. 92–03; *LaChance v. Erickson* (1998) 522 U.S. 262, 267–268, 118 S.Ct. 753 [holding that a federal employee can be charged with dishonesty for giving false denials of charged misconduct during an agency's investigatory interview even though the denials were not made under oath; noting that "any ***807** claim that employees not allowed to make false statements might be coerced into admitting misconduct, whether they believe that they are guilty or not, in order to avoid the more severe penalty of removal for falsification is entirely frivolous."])

Moreover, the lying here involved repeated dishonest denials of allegations relating to the underlying misconduct. We do not find that such repeated denials are mere denials of underlying charges to which *Alameida* limited itself. (*Alameida, supra,* 120 Cal.App.4th at p. 62 fn. 10, 15 Cal.Rptr.3d 383 But cf. *Brogan v. U.S.* (1998) 522 U.S. 398, 118 S.Ct. 805, 139 L.Ed.2d 830 [rejecting argument that federal statute criminalizing making of false statements has an unwritten exception for the " 'exculpatory no,' " a simple denial of guilt.])

Also, appellants were charged only a few months after the statute of limitations had expired on the underlying misconduct, and they were charged with lying within the limitations period of section 19635. These factual circumstances distinguish this case from *Alameida.* The *Alameida* court, and the SPB in this case, was concerned that discipline should be adjudicated while memories are fresh in order to prevent the hardship and injustice of having to defend against stale claims. (*Alameida, supra,* 120 Cal.App.4th at p. 62, 15 Cal.Rptr.3d 383.) In this case, however, appellants do not contend that CDC presented witnesses at the hearing before the ALJ whose memories have faded, or that the evidence presented at the hearing was stale, or that exculpatory evidence was lost. As another appellate court has observed, "the policy behind statutes of limitation, which the United States Supreme Court long ago noted is to 'promote justice by preventing ****673** surprises through the revival of claims that have been allowed to slumber until evidence has been lost, memories have faded and witnesses have disappeared.' [Citations.] No claim slumbered here. No evidence was lost. No witnesses disappeared. Not by a long shot." (*Parra v. City and County of San Francisco* (2006) 144 Cal.App.4th 977, 998, 50 Cal.Rptr.3d 822, 838.) FN6

> FN6. We note that the Legislature determines limitations period for policy rationales other than just prevention of surprises through the revival of stale claims. For example, an examination of the limitations periods for crimes suggests that the limitations period depends, to some extent, on the gravity of the crime. Thus, we have no statute of limitations for very serious crimes such as murder (Pen.Code, § 799), six-year limitations period for crimes such as arson causing bodily injury (Penal Code, § 800), and three-year limitations period for other lesser crimes (Pen.Code, § 801), even though witnesses' memories may have deteriorated in the same manner for these crimes.

Appellants argue that permitting dishonesty claims to survive when the dishonest denials occurred within the limitations period of the underlying charges would effectively extend the three-year limitations period in section 19635 into a six-year limitations period for dishonesty charges. According to ***808** appellants, such a holding would permit "a public agency [to] interview an employee about a prior act of misconduct just days before the lapse of the three year limitations period upon that act of prior misconduct, then wait another three years before serving the employee with a notice of adverse action alleging charges of dishonesty based upon the employee's denial at the interview, of any involvement in that prior act of misconduct. This puts an employee in the position of having to defend against prior acts of misconduct over six years old."

Appellants overstate their case. The hypothetical situation presented by appellants is not the situation that occurred in the present case. (*Sulier v. State Personnel Bd.* (2004) 125 Cal.App.4th 21, 30, 22 Cal.Rptr.3d 615.) Here, appellants only had to defend

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statements that they made approximately two years before, well within the three-year limitations period of section 19635.

Finally, public policy considerations—including the fact that correctional officers are involved, California's policy against hiring dishonest employees, and the policy favoring honesty over dishonesty—support our finding that extensive lying does not merge with underlying offense.

First, this case involves state employees who work in our correctional facilities. Appellants are public employees to whom we entrust the care and rehabilitation of criminals. Moreover, two of the appellants are peace officers who are held to a higher standard of conduct than other public employees. (*Flowers v. State Personnel Bd.* (1985) 174 Cal.App.3d 753, 759, 220 Cal.Rptr. 139, 142.) As such, to find that their lies merge with underlying misconduct and thus are barred by section 19635 would permit appellants to conduct themselves in a manner unbefitting correctional employees.

Second, "[p]ublic employees are trustees of the public interest and thus owe a special duty of integrity." (*Long Beach City Employees Assn. v. City of Long Beach* (1986) 41 Cal.3d 937, 952, 227 Cal.Rptr. 90, 99.) Moreover, "[b]y its enactment of section 19572, subdivision (f), the Legislature indicated a strong public policy against having dishonest employees in the state service." (*Gee v. California State Personnel Bd.* (1970) 5 Cal.App.3d 713, 719, 85 Cal.Rptr. 762, 769.) To permit appellants who lied during investigatory interviews and who were charged with violations of ****674** section 19572, subdivision (f), to escape unscathed would be contrary to the strong public policy against having dishonest public employees.

Lastly, a contrary finding would encourage lying during investigative interviews because there are no consequences for lying if the lie is not caught prior to the expiration of the limitations period on the underlying misconduct. For example, a finding that the lies merge with the underlying offense would ***809** encourage a rational person to lie where the investigatory interview into misconduct occurred towards the end of the limitations period, as it would be unlikely for the investigator to discover that the denials were lies within the limitations period.

Thus, policy considerations support finding that appellants' extensive lying do not merge with the underlying misconduct. Therefore, section 19635 does not bar the dishonesty charges in this case.

DISPOSITION

The judgment is affirmed.

WE CONCUR: LEVY, and GOMES, JJ.

Cal.App. 5 Dist.,2007.
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147 Cal.App.4th 797, 54 Cal.Rptr.3d 665, 25 IER Cases 1476, 07 Cal. Daily Op. Serv. 1625

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Supreme Court of California
Patrick O'RIORDAN, Plaintiff and Appellant,
v.
FEDERAL KEMPER LIFE ASSURANCE, Defendant and Appellant.

No. S115495.
July 7, 2005.

Background: Beneficiary of decedent's life insurance sued insurer, which had rescinded policy and denied beneficiary's claim on ground that insured had concealed her smoking of cigarettes in 36-month period preceding her application thereby obtaining "preferred nonsmoker rate." The Superior Court, Sacramento County, No. 99AS04726, Joe S. Gray, J., granted insurer summary judgment. Beneficiary appealed. The Court of Appeal affirmed, and the Supreme Court granted beneficiary's petition for review.

Holdings: The Supreme Court, Kennard, J., held that:
(1) material issue of fact remained whether insured concealed her smoking, and
(2) agent's knowledge of insured's smoking was imputed to insurer.

Judgment of the Court of Appeal reversed and matter remanded.

West Headnotes

[1] Appeal and Error 30 863

30 Appeal and Error
30XVI Review
30XVI(A) Scope, Standards, and Extent, in General
30k862 Extent of Review Dependent on Nature of Decision Appealed from
30k863 k. In General. Most Cited Cases

On a plaintiff's appeal from the trial court's grant of summary judgment against him, the Supreme Court must independently examine the record in order to determine whether triable issues of fact exist to reinstate the action.

[2] Appeal and Error 30 893(1)

30 Appeal and Error
30XVI Review
30XVI(F) Trial De Novo
30k892 Trial De Novo
30k893 Cases Triable in Appellate Court
30k893(1) k. In General. Most Cited Cases

Appeal and Error 30 895(2)

30 Appeal and Error
30XVI Review
30XVI(F) Trial De Novo
30k892 Trial De Novo
30k895 Scope of Inquiry
30k895(2) k. Effect of Findings Below. Most Cited Cases

In performing its de novo review of a summary judgment against a plaintiff, the Supreme Court views the evidence in the light most favorable to plaintiff and liberally construes plaintiff's evidence and strictly scrutinizes that of defendant in order to resolve any evidentiary doubts or ambiguities in plaintiff's favor.

[3] Insurance 217 3019

217 Insurance
217XXIV Avoidance
217XXIV(C) Special Circumstances Affecting Risk
217k3019 k. Habits. Most Cited Cases

When an applicant for life insurance misrepresents his or her history as a smoker in order to obtain a nonsmoker rate, the insurer may rescind the policy. West's Ann.Cal.Ins.Code §§ 330–332, 334, 359.

[4] Judgment 228 181(23)

228 Judgment
228V On Motion or Summary Proceeding
228k181 Grounds for Summary Judgment
228k181(15) Particular Cases
228k181(23) k. Insurance Cases. Most Cited Cases

Material issue of fact remained whether insured under life insurance policy concealed her smoking to obtain "preferred nonsmoker rate," thus precluding summary judgment for insurer in insurance beneficiary's action against insurer which had rescinded policy after insured died; applicant, who had smoked one or two cigarettes in 36-month period preceding her application, answered "no" to two questions, the question "Have you smoked cigarettes in the past 36 months?" could reasonably be construed as meaning habitual smoking, and "Have you used tobacco in any other form in the past 36 months?" could be construed as referring to tobacco products other than cigarettes. West's Ann.Cal.Ins.Code §§ 330–332, 334, 359.
See 1 Witkin, Summary of Cal. Law (9th ed. 1987) Contracts, § 415A; Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2004) ¶ 15:921 et seq. (CAINSL Ch. 15-I); Cal. Jur. 3d, Insurance Contracts and Coverage, § 167 et seq.

[5] Insurance 217 ⚷1606

217 Insurance
217XI Agents and Agency
217XI(A) In General
217k1605 Agency for Insurer or Insured
217k1606 k. In General. Most Cited Cases

Insurance 217 ⚷1644

217 Insurance
217XI Agents and Agency
217XI(C) Agents for Insurers
217k1643 Duties and Liabilities of Agent to Insurer
217k1644 k. In General. Most Cited Cases

Insurance 217 ⚷3091

217 Insurance
217XXVI Estoppel and Waiver of Insurer's Defenses
217k3088 Knowledge or Notice of Facts in General
217k3091 k. Officers or Agents; Imputed Knowledge. Most Cited Cases

Independent agent's knowledge that life insurance applicant had smoked one or two cigarettes in 36-month period preceding application was imputed to insurer; agent became insurer's agent when he assisted applicant in responding to insurer's medical questionnaire, agent therefore had duty to disclose to insurer any material information regarding application, and insurer was deemed to have knowledge of such facts even though insured denied tobacco use in her application. West's Ann.Cal.Ins.Code §§ 330–332, 334, 359.

[6] Principal and Agent 308 ⚷177(1)

308 Principal and Agent
308III Rights and Liabilities as to Third Persons
308III(E) Notice to Agent
308k177 Imputation to Principal in General
308k177(1) k. In General. Most Cited Cases

Knowledge acquired by agent is imputed to the principal even when the knowledge was not actually communicated to the principal.

[7] Principal and Agent 308 ⚷179(2)

308 Principal and Agent
308III Rights and Liabilities as to Third Persons
308III(E) Notice to Agent
308k179 Time of Notice to Agent
308k179(2) k. Knowledge Acquired Previous to Agency. Most Cited Cases

A principal is charged with knowledge which his agent acquires before the commencement of the agency relationship when that knowledge can reasonably be said to be present in the mind of the agent while acting for the principal.

[8] Judgment 228 ⚷181(2)

228 Judgment
228V On Motion or Summary Proceeding
228k181 Grounds for Summary Judgment

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228k181(2) k. Absence of Issue of Fact. Most Cited Cases

When a dispositive factual issue is disputed, summary judgment is improper.

***508 Wohl Sammis Christian & Perkins, Wohl Sammis & Perkins, Alvin R. Wohl, Robin K. Perkins and Christopher F. Wohl, Sacramento, for Plaintiff and Appellant.

Sarrail, Lynch & Hall, Vogl & Meredith, Linda J. Lynch and David A. Firestone, San Francisco, for Defendant and Appellant.

KENNARD, J.

283 **754** After his wife's death from breast cancer, plaintiff, as beneficiary of his wife's life insurance policy, sought to collect the policy proceeds. Defendant insurance company, however, rescinded the policy and denied plaintiff's claim. It asserted that the wife had concealed from the insurer her smoking of cigarettes in the 36–**509** month period preceding her application, and that had she been truthful it would not have issued a policy at the "preferred nonsmoker rate." Plaintiff sued. The trial court granted the insurer's motion for summary judgment. We conclude that whether there was concealment is a disputed material fact, and therefore summary judgment was improper.

***284 I**

[1][2] Because plaintiff has appealed from the trial court's grant of summary judgment against him, we must "independently examine the record in order to determine whether triable issues of fact exist to reinstate the action." (*Wiener v. Southcoast Childcare Centers, Inc.* (2004) 32 Cal.4th 1138, 1142, 12 Cal.Rptr.3d 615, 88 P.3d 517; see also ****755***Saelzler v. Advanced Group 400* (2001) 25 Cal.4th 763, 767, 107 Cal.Rptr.2d 617, 23 P.3d 1143.) "In performing our de novo review, we view the evidence in the light most favorable to plaintiff[ ]" (*Wiener, supra,* at p. 1142, 12 Cal.Rptr.3d 615, 88 P.3d 517), and we "liberally construe" plaintiff's evidence and "strictly scrutinize" that of defendant "in order to resolve any evidentiary doubts or ambiguities in [plaintiff's] favor" (*ibid.*). Viewed in that light, these are the facts here:

In 1996, plaintiff Patrick O'Riordan and his wife Amy consulted Robert Hoyme, an independent insurance agent, for the purpose of replacing their life insurance policies with term life insurance. Hoyme suggested a policy issued by defendant Federal Kemper Life Assurance Company (Kemper). In the course of two meetings with Hoyme, the O'Riordans filled out application forms for Kemper policies at the preferred nonsmoker rate.

The insurance applications had a medical questionnaire, which asked these two questions: (1) "Have you smoked cigarettes in the past 36 months?," and (2) "Have you used tobacco in any other form in the past 36 months?" According to plaintiff, his wife, Amy, had smoked for many years but quit in 1991, five years before submitting her application. Amy told Hoyme that she had been a smoker and that her previous life insurance policy was a smokers' policy. She also mentioned that she "might have had a couple of cigarettes in the last couple of years." Hoyme replied: "That's not really what they're looking for. They're looking for smokers." He explained that the O'Riordans would have to undergo blood and urine tests to determine whether their bodies contained any traces of smoking. Someone—the record does not say whether it was Hoyme or Amy—checked the boxes marked "No" next to the two questions at issue. A doctor, approved and paid for by Kemper, examined Amy and took blood and urine samples, which showed no traces of nicotine.

Although Hoyme had been an independent agent for many years, he had not previously sold insurance for Kemper. He submitted a request to be appointed as Kemper's agent, along with the O'Riordans' policy application forms, to Cenco Insurance Marketing Corporation, a general agent for Kemper with authority to recruit agents. On May 24, 1996, two days after the ***285** O'Riordans had filled out their applications, Cenco approved Hoyme's request to be appointed a Kemper agent. On June 28, 1996, Kemper issued a term life insurance policy to Amy at the preferred nonsmoker rate, listing plaintiff as the beneficiary. Kemper paid Hoyme a monthly commission as its agent on the policy.

In November 1997, Amy was diagnosed with metastatic breast cancer. When Amy learned that she had only a short time to live, she began smoking again. She died *****510** on June 26, 1998, two days before the policy's two-year contestability period expired.

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When plaintiff sought to collect on Amy's life insurance policy, Kemper conducted an investigation and learned that in July 1995, less than a year before Amy applied for the policy, Amy had asked her physician for, and received, a nicotine patch. The physician's report stated that although Amy had quit smoking several years previously, "recently, due to some stressors, she did start to smoke a little bit again, but is not smoking as much as she smoked previously." Based primarily on this information, Kemper concluded that Amy had falsely answered the application's questions pertaining to her smoking. It denied plaintiff's claim, and it rescinded the policy it had issued to Amy.

Plaintiff then filed this action in superior court against Kemper, Cenco, and Hoyme. As amended, his complaint sought damages for breach of contract, breach of the covenant of good faith and fair dealing, negligence, fraud, negligent misrepresentation, and emotional distress. After plaintiff settled with Hoyme, the court, at plaintiff's request, dismissed the complaint against Cenco, leaving only Kemper as a defendant.

Kemper moved for summary judgment or summary adjudication, claiming the facts were undisputed that Amy falsely answered the application's questions about smoking and tobacco use in the 36 months preceding her application, thus entitling Kemper to rescind Amy's life insurance policy. Kemper added that had Amy told the truth it would not have issued the policy. In his response, ****756** plaintiff admitted that Amy had smoked a couple of cigarettes in 1995 but said that this was the full extent of her smoking in the 36–month period preceding her application, and that she had obtained the nicotine patch as a precautionary measure. Plaintiff asserted that Amy had accurately described her cigarette usage to Hoyme when she applied for the insurance policy. The trial court granted Kemper's motion and entered judgment for Kemper. Plaintiff appealed.

***286** In a two-to-one decision, the Court of Appeal affirmed the judgment. Justice Nicholson's lead opinion concluded that even if Amy had smoked only two cigarettes in the 36 months preceding her application, she concealed the extent of her cigarette usage because she answered "no" to the questions in the application pertaining to her cigarette and tobacco usage in that period. The lead opinion described Kemper's two questions about Amy's use of tobacco as "a term of the [insurance] contract," which unambiguously required Amy to answer "yes" to each question if she had smoked even one cigarette during the 36–month period at issue. Although the lead opinion concluded that insurance salesman Hoyme was Kemper's agent when he assisted Amy in answering those two questions, it reasoned that Hoyme's actual and ostensible authority "did not extend to interpreting an unambiguous term in the insurance."

Justice Blease concurred in the result, but on different grounds. In his view, based on the report of Amy's doctor who had given her the nicotine patch, Amy's smoking "was not confined to a couple of cigarettes but was a continuous problem...." Thus, he concluded, she "concealed the true extent of her smoking ... which justifies rescission of the policy...."

Justice Hull dissented. He concluded that Kemper was estopped from asserting any concealment by Amy of her cigarette use, because she did tell Hoyme, whom Justice Hull viewed as Kemper's agent, that she had smoked a couple of cigarettes in the two years before her application. *****511** Moreover, Justice Hull said, Hoyme had "the ostensible authority to advise Amy O'Riordan of the information the insurance company needed to decide whether to issue a nonsmoker's policy...."

We granted plaintiff's petition for review.

II

Under California law, every party to an insurance contract must "communicate to the other, in good faith, all facts within his knowledge which are ... material to the contract ... and which the other has not the means of ascertaining." (Ins.Code, § 332.) [FN1] "Materiality" is determined by "the probable and reasonable influence of the facts upon the party to whom the communication is due...." (§ 334.)

FN1. All statutory citations are to the Insurance Code unless otherwise stated.

[3] When an insured has engaged in "concealment," which is defined by statute as the "[n]eglect to communicate that which a party knows, and ought to communicate" (§ 330), the insurer may rescind the policy, even if the act ***287** of concealment was un-

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intentional (§ 331). Similarly, a materially false representation at the time of, or before, issuance of a policy may result in rescission of the policy. (§ 359.) Thus, when an applicant for life insurance misrepresents his or her history as a smoker in order to obtain a nonsmoker rate, the insurer may rescind the policy. (*Old Line Life Ins. Co. v. Superior Court* (1991) 229 Cal.App.3d 1600, 1603–1606, 281 Cal.Rptr. 15.)

[4] Kemper asserts that the facts are undisputed that Amy concealed the true extent of her cigarette use during the 36–month period preceding her application for life insurance. But plaintiff argues that Kemper is estopped from asserting any concealment by Amy because Hoyme, who plaintiff claims was Kemper's agent when he sold Amy the policy, told Amy she could answer "no" to Kemper's two questions inquiring into her smoking during the period at issue. Alternatively, plaintiff argues that Hoyme had ostensible authority to construe the meaning of the questions and that in advising Amy to respond "no" to the questions at issue, he misrepresented their meaning. (See **757 6 Couch on Insurance (3d ed.1997) § 85:44, p. 85–67 ["If the insurer's agent construes the questions [in an insurance application] either by stating what they mean or by specifically stating that certain information is or is not required, any misrepresentations which result therefrom are charged to the insurer, the theory being that the insurer's agent remains the insurer's agent even though he or she is assisting the insured."]; see also 3 Appleman on Insurance 2d (Holmes ed.1998) § 10.4, p. 12.)

Here, we need not decide the merits of plaintiff's claims of estoppel and ostensible authority. As we will explain, regardless of how those questions are resolved, it is a triable issue of fact whether Amy concealed or failed to communicate material information to Kemper regarding her use of cigarettes in the 36 months preceding her application for life insurance at a nonsmoker rate. Therefore, the trial court erred in granting Kemper's summary judgment motion.

Pertinent are Amy's answers to the two questions in Kemper's medical questionnaire inquiring into her cigarette and tobacco usage. The first question asked, "Have you smoked cigarettes in the past 36 months?" That inquiry can reasonably be construed as an attempt to determine *habitual* use, not the smoking of a single cigarette or two during that entire period. Had Kemper intended disclosure of the ***512 latter, it could have inquired into the smoking of "any" cigarette during the relevant period. The second question asked: "Have you used tobacco *in any other form* in the past 36 months?" *288 Italics added.) Because this question directly followed the question pertaining to *cigarette* use, an applicant could reasonably construe it as inquiring into use of tobacco in any form *other than cigarettes.* Therefore, an applicant who, like Amy, has smoked just a couple of cigarettes but has not used tobacco in any other form during the period at issue could correctly answer "no" to this question.

Thus, if (as plaintiff maintains) Amy smoked only a cigarette or two during the 36 months preceding her application and did not use any other tobacco products, she did not conceal her cigarette usage by answering "no" to the two questions at issue.

[5][6] Moreover, even if, as Kemper insists, those two questions required disclosure of even a single cigarette smoked during the period at issue, Amy did not conceal that information from Kemper, because she did mention it to Hoyme when she applied for the life insurance. Although Hoyme was not Kemper's agent when he assisted Amy in responding to Kemper's medical questionnaire, he became one when his request to be so appointed—submitted with Amy's application—was granted. (See generally Ins.Code, § 1704.5.) Once he became Kemper's agent, Hoyme had a duty to disclose to Kemper any material information he had pertaining to Amy's life insurance policy, and Kemper is deemed to have knowledge of such facts. (*In re Marriage of Cloney* (2001) 91 Cal.App.4th 429, 439, 110 Cal.Rptr.2d 615 ["As a general rule, an agent has a duty to disclose material matters to his or her principal, and the actual knowledge of the agent is imputed to the principal."]; Civ.Code, § 2332 ["As against a principal, both principal and agent are deemed to have notice of whatever either has notice of, and ought, in good faith and the exercise of ordinary care and diligence, to communicate to the other."].) Therefore, Hoyme's knowledge of Amy's smoking of one or two cigarettes during the 36 months preceding the application was imputed to Kemper. "The fact that the knowledge acquired by the agent was not actually communicated to the principal ... does not prevent operation of the rule." (*Columbia Pictures Corp. v. DeToth* (1948) 87 Cal.App.2d 620, 630, 197 P.2d 580.)

[7] Nor does it matter that Hoyme acquired the

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information regarding Amy's cigarette use before he became Kemper's agent. "The principal is charged with knowledge which his agent acquires before the commencement of the relationship when that knowledge can reasonably be said to be present in the mind of the agent while acting for the principal." (*Columbia Pictures Corp. v. DeToth, supra,* 87 Cal.App.2d at p. 631, 197 P.2d 580; see also *Schiffman v. Richfield Oil Co.* (1937) 8 Cal.2d 211, 220-221, 64 P.2d 1081; Rest.2d Agency, § 276.) Here, because Hoyme became Kemper's agent shortly after acquiring information about Amy's ****758** smoking, his knowledge of her smoking ***289** "can reasonably be said to be present in [his] mind" (*Columbia Pictures Corp., supra,* 87 Cal.App.2d at p. 631, 197 P.2d 580) while he was acting as Kemper's agent.

Kemper contends that Amy did not tell Hoyme that she had smoked any cigarettes during the 36 months preceding the application.[FN2] And Kemper points to the *****513** medical report by Amy's physician who, at Amy's request, prescribed a nicotine patch in the year preceding her application, as evidence that Amy smoked more than just "a couple" of cigarettes in the period at issue. Based on the medical report, Justice Blease concluded in his concurring opinion that Kemper was entitled to summary judgment because Amy's cigarette use "was not confined to a couple of cigarettes but was a continuous problem."

> FN2. Although Hoyme testified in his deposition that he did not recall Amy telling him that she had smoked two cigarettes during the 36 months preceding the application, he did remember having "some conversation [with Amy] or a question ... about, you know, having, you know, a cigarette ... in the past, you know, at a special function or something like that...." He also said that he often told applicants that "if you have one [cigarette] once or twice a year, then it's probably not a big deal."

[8] But the question of Amy's cigarette use is a disputed material fact. In response to Kemper's motion for summary judgment, plaintiff declared that Amy had quit smoking in 1991 (more than three years before her life insurance application) and, apart from two cigarettes Amy shared with her sister during the three-year period at issue, she did not resume smoking until after she was diagnosed with terminal cancer in 1997, the year after submitting her application. Plaintiff also submitted a corroborating declaration by Amy's sister, Pamela Inouye, who said that to her knowledge the only cigarettes Amy smoked from 1991 to 1997 were a couple of cigarettes the two of them shared. When, as here, a dispositive factual issue is disputed, summary judgment is improper. (*Guz v. Bechtel National, Inc.* (2000) 24 Cal.4th 317, 334, 100 Cal.Rptr.2d 352, 8 P.3d 1089.)

In their briefs, the parties address the question whether the trial court should have granted Kemper's motion for summary adjudication of certain causes of action in plaintiff's amended complaint. The Court of Appeal did not address these issues, for its conclusion that Amy had materially misrepresented the extent of her smoking during the 36 months preceding her application, thus entitling Kemper to rescind Amy's policy, necessarily disposed of plaintiff's entire complaint. Nor were these issues encompassed in our grant of review. We therefore do not consider them here.

***290 CONCLUSION**

We reverse the judgment of the Court of Appeal, and we remand the matter to that court for further proceedings consistent with this opinion.

WE CONCUR: GEORGE, C.J., BAXTER, WERDEGAR, CHIN, and MORENO, JJ.

Cal.,2005.
O'Riordan v. Federal Kemper Life Assur.
36 Cal.4th 281, 114 P.3d 753, 30 Cal.Rptr.3d 507, 05 Cal. Daily Op. Serv. 5984, 2005 Daily Journal D.A.R. 8177

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EXHIBIT E

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BEFORE THE
COMMISSION ON STATE MANDATES
STATE OF CALIFORNIA

Claim Of: County of San Bernardino Claimant	No. CSM-4282 Title 2, Cal. Code Regs., Div. 9, Sections 60000-60200 Chapter 1747, Statutes of 1984 Chapter 1274, Statutes of 1985 ***Handicapped and Disabled Students***

PARAMETERS AND GUIDELINES

The attached ***amended*** Parameters and Guidelines of the Comrnission on State Mandates are hereby adopted by the Commission on State Mandates in the above entitled matter.

IT IS SO ORDERED August 29, 1996.

K.G. Stewart

Kirk G. Stewart, Executive Director
Cornmission on State Mandates

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FILE COPY

Hearing Date: August 29, 1996
File Number: CSM-4282
Commission Staff: Lucila Ledesma
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Original Adopted: 8/22/9 1
Revised: **8/29/96**

PARAMETERSANDGUIDELINES

Sections 60000-60200
Title 2, California Code of Regulations, Division 9
Chapter 1747, Statutes of 1984
Chapter 1274, Statutes of 1985
Handicapped and Disabled Students

I. SUMMARY OF MANDATE

Chapter 1747 of the Statutes of 1984 added Chapter 26, commencing with section 7570, to Division 7 of Title 1 of the Government code (Gov. Code).

Chapter 1274 of the Statutes of 1985 amended sections 7572, 7572.5, 7575, 7576, 7579, 7582, and 7587 of, amended and repealed 7583 of, added section 7586.5 and 7586.7 to, and repealed 7574 of, the Gov. Code, and amended section 5651 of the Welfare and Institutions Code.

To the extent that Gov. Code section 7572 and section 60040, Title 2, Code of California Regulations, require county participation in the mental health assessment for "'individuals with exceptional needs, " such legislation and regulations impose a new program or higher level of service upon a county. Furthermore, any related county participation on the expanded "Individualized Education Program" (IEP) team and case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed, " pursuant to subdivisions (a), (b), and (c) of Gov. Code section 7572.5 and their implementing regulations, impose a new program or higher level of service upon a county.

The aforementioned mandatory county participation in the IEP process is not subject to the Short-Doyle Act, and accordingly, such costs related thereto are costs mandated by the state and are fully reimbursable within the meaning of section 6, article XIIIB of the California Constitution.

The provisions of Welfare and Institutions Code section 565 1, subdivision (g), result in a higher level of service within the county Short-Doyle program because the mental health services, pursuant to Gov. Code sections 757 1 and 7576 and their implementing regulations, must be included in the county Short-Doyle annual plan. Such services include psychotherapy and other mental health services provided to "individuals with exceptional needs, " including those designated as "seriously emotionally disturbed, " and required in such individual's IEP.

Such mental health services are subject to the current cost sharing formula of the Short-Doyle Act, through which the state provides ninety (90) percent of the total costs of the Short-Doyle program, and the county is required to provide the remaining ten (10) percent of the funds. Accordingly, only ten (10) percent of such program costs are reimbursable within the meaning of section 6, article XIIIB of the California Constitution as costs mandated by the state, because the Short-Doyle Act currently provides counties ninety (90) percent of the costs of furnishing those mental health services set forth in Gov. Code section 757 1 and 7576 and their implementing regulations, and described in the county's Short-Doyle annual plan pursuant to Welfare and Institutions Code section 565 1, subdivision (g).

II. COMMISSION ON STATE MANDATES' DECISION

The Commission on State Mandates, at its April 26, 1990 hearing, adopted a Statement of Decision that determined that County participation in the IEP process is a state mandated program and any costs related thereto are fully reimbursable. Furthermore, any mental health treatment required by an IEP is subject to the Short-Doyle cost sharing formula. Consequently, only the county's Short-Doyle share (i.e., ten percent) of the mental health treatment costs will be reimbursed as costs mandated by the state.

III. ELIGIBLE CLAIMANTS

All counties

IV. PERIOD OF REIMBURSEMENT

Section 17557 of the Gov. Code states that a test claim must be submitted on or before December 3 1 following a given fiscal year to establish eligibility for that year. The test claim for this mandate was filed on August 17, 1987, all costs incurred on or after July 1, 1986, are reimbursable.

Actual costs for one fiscal year should be included in each claim, and estimated costs for the subsequent year may be included on the same claim, if applicable, pursuant to Government Code section 17561.

If the total costs for a given fiscal year do not exceed $200, no reimbursement shall be allowed, except as otherwise allowed by Gov. Code section 17564.

V. REIMBURSABLE COSTS

A. One Hundred (100) percent of any costs related to IEP Participation, Assessment, and Case Management:

1. The scope of the mandate is one hundred (100) percent reimbursement, except that for individuals billed to Medi-Cal only, the Federal Financing Participation portion (FFP) for these activities should be deducted from reimbursable activities not subject to the Short-Doyle Act.

2. For each eligible claimant, the following cost items are one hundred (100) percent reimbursable (Gov. Code, section 7572, subd. (d)(1)):

   a. Whenever an LEA refers an individual suspected of being an 'individual with exceptional needs' to the local mental health department, mental health assessment and recommendation by qualified mental health professionals in conformance with assessment procedures set forth in Article 2 (commencing with section 56320) of Chapter 4 of part 30 of Division 4 of the Education Code, and regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, including but not limited to the following mandated services:
   i. interview with the child and family,
   ii. collateral interviews, as necessary,
   iii. review of the records,
   iv. observation of the child at school, and
   v. psychological testing and/or psychiatric assessment, as necessary.

   b. Review and discussion of mental health assessment and recommendation with parent and appropriate IEP team members. (Government Code section 7572, subd. (d)(1)).

   c. Attendance by the mental health professional who conducted the assessment at IEP meetings, when requested. (Government Code section 7572, subd. (d)(1)).

   d. Review by claimant's mental health professional of any independent assessment(s) submitted by the IEP team. (Government Code section 7572, subd. (d)(2)).

   e. When the written mental health assessment report provided by the local mental health program determines that an "individual with special needs' is 'seriously emotionally disturbed', and any member of the IEP team recommends residential placement based upon relevant assessment information, inclusion of

the claimant's mental health professional on that individual's expanded IEP team.

f. When the IEP prescribes residential placement for an 'individual with exceptional needs ' who is 'seriously emotionally disturbed, ' claimant' s mental health personnel's identification of out-of-home placement, case management, six month review of IEP, and expanded IEP responsibilities. (Government Code section 7572.5).

g. Required participation in due process procedures, including but not limited to due process hearings.

3. One hundred (100) percent of any administrative costs related to IEP Participation, Assessment, and Case Management, whether direct or indirect.

B. Ten (10) percent of any costs related to mental health treatment services rendered under the Short-Doyle Act :

1. The scope of the mandate is ten (10) percent reimbursement.

2. For each eligible claimant, the following cost items, for the provision of mental health services when required by a child's individualized education program, are ten (10) percent reimbursable (Government Code 7576):

a. Individual therapy,

b. Collateral therapy and contacts,

c. Group therapy,

d. Day treatment, and

e. Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.

3. Ten (10) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

Vi. CLAIM PREPARATION

There are two satisfactory methods of submitting claims for reimbursement of increased costs incurred to comply with the mandate:

A. Actual Increased Costs Method. To claim under the Actual Increased Costs Method, report actual increased costs incurred for each of the following expense categories in the format specified by the State Controller's claiming instructions. Attach supporting schedules as necessary:

1. Employee Salaries and Benefits: Show the classification of the employees involved, mandated functions performed, number of hours devoted to the function, and hourly rates and benefits.

2. Services and supplies: Include only expenditures which can be identified as a direct cost resulting from the mandate. List cost of materials acquired which have been consumed or expended specifically for the purpose of this mandate.

3. Direct Administrative Costs:

   a. One hundred (100) percent of any direct administrative costs related to IEP Participation, Assessment, and Case Management.

   b. Ten (10) percent of any direct administrative costs related to mental health treatment rendered under the Short-Doyle Act.

4. Indirect Administrative and Overhead Costs: To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions:

   a. Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs which exceeds ten (10) percent of total program direct labor costs, excluding fringe benefits.

   OR if an indirect cost rate greater than ten (10) percent is being claimed,

   b. By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program; each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP(s).

B. Cost Report Method. Under this claiming method the mandate reimbursement claim is still submitted on the State Controller's claiming forms in accordance with the claiming instructions. A complete copy of the annual cost report including all supporting schedules attached to the cost report as filed with DMH must also be filed with the claim forms submitted to the State Controller.

1. To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions :

   a. Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs which exceeds ten (10) percent of total program direct labor costs, excluding fringe benefits.

   OR if an indirect cost rate greater than ten (10) percent is being claimed,

   b. By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program; each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP(s).

VII. SUPPORTING DATA

For auditing purposes, all costs claimed must be traceable to source documents and/or worksheets that show evidence of the validity of such costs. Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district is subject to audit by the State Controller no later than two years after the end of the calendar year in which the reimbursement claim is filed or last amended. However, if no funds are appropriated for the program for the fiscal year for which the claim is made, the time for the State Controller to initiate an audit shall commence to run from the date of initial payment of the claim.

VIII. OFFSETTING SAVINGS AND OTHER REIMBURSEMENTS

A. Any offsetting savings the claimant experiences as a direct result of this statute must be deducted from the costs claimed.

B. The following reimbursements for this mandate shall be deducted from the claim:

1. Any direct payments (categorical funding) received from the State which are specifically allocated to this program; and

2. Any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g. federal, state, etc.

IX. REQUIRED CERTIFICATION

An authorized representative of the claimant will be required to provide a certification of claim, as specified in the State Controller's claiming instructions, for those costs mandated by the state contained herein.

BEFORE THE
COMMISSION ON STATE MANDATES
STATE OF CALIFORNIA

RECONSIDERATION OF PRIOR STATEMENT OF DECISION ON: Statutes 1984, Chapter 1747; Statutes 1985, Chapter 1274; California Code of Regulations, Tit. 2, Div. 9, §§ 60000-60610 (Emergency Regulations filed December 31, 1985, Designated Effective January 1, 1986 (Register 86, No. 1) and Refiled June 30, 1986, Designated Effective July 12, 1986 (Register 86, No. 28)) CSM 4282 Directed By Statutes 2004, Chapter 493, Section 7, (Sen. Bill No. 1895) Effective September 13, 2004.	**Case No.: 04-RL-4282-10** ***Handicapped & Disabled Students*** STATEMENT OF DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; CALIFORNIA CODE OF REGULATIONS, TITLE 2, DIVISION 2, CHAPTER 2.5, ARTICLE 7 (*Adopted on May 26, 2005*)

STATEMENT OF DECISION

The attached Statement of Decision of the Commission on State Mandates is hereby adopted in the above-entitled matter.

______________________________ ______________________

PAULA HIGASHI, Executive Director Date

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

RECONSIDERATION OF PRIOR STATEMENT OF DECISION ON:

Statutes 1984, Chapter 1747; Statutes 1985, Chapter 1274; California Code of Regulations, Tit. 2, Div. 9, §§ 60000-60610 (Emergency Regulations filed December 31, 1985, Designated Effective January 1, 1986 (Register 86, No. 1) and Refiled June 30, 1986, Designated Effective July 12, 1986 (Register 86, No. 28)) CSM 4282

Directed By Statutes 2004, Chapter 493, Section 7, (Sen. Bill No. 1895)

Effective September 13, 2004.

Case No.: 04-RL-4282-10

Handicapped & Disabled Students

STATEMENT OF DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; CALIFORNIA CODE OF REGULATIONS, TITLE 2, DIVISION 2, CHAPTER 2.5, ARTICLE 7

(*Adopted on May 26, 2005*)

STATEMENT OF DECISION

The Commission on State Mandates ("Commission") heard and decided this test claim during a regularly scheduled hearing on May 26, 2005. Leonard Kaye and Paul McIver appeared on behalf of the County of Los Angeles. Pam Stone represented and appeared on behalf of the County of Stanislaus. Linda Downs appeared on behalf of the County of Stanislaus. John Polich appeared on behalf of the County of Ventura. Patricia Ryan appeared on behalf of the California Mental Health Directors' Association. Jeannie Oropeza and Dan Troy appeared on behalf of the Department of Finance.

The law applicable to the Commission's determination of a reimbursable state-mandated program is article XIII B, section 6 of the California Constitution, Government Code section 17500 et seq., and related case law.

The Commission adopted the staff analysis at the hearing by a vote of 4-0.

BACKGROUND

Statutes 2004, chapter 493 (Sen. Bill No. 1895 ("SB 1895")) directs the Commission to reconsider its prior final decision and parameters and guidelines on the *Handicapped and Disabled Students* program. Section 7 of the bill states the following:

> Notwithstanding any other law, the Commission on State Mandates shall, on or before December 31, 2005, reconsider its decision relating to included services and administrative and travel costs associated with services provided pursuant to Chapter 26.5 (commencing with

Section 7570) of Division 7 of Title 1 of the Government Code, and the parameters and guidelines for calculating the state reimbursements for these costs.

Commission Decisions

The Commission adopted the Statement of Decision on the *Handicapped and Disabled Students* program in 1990 (CSM 4282). Generally, the test claim legislation implements federal law that requires states to guarantee to disabled pupils the right to receive a free and appropriate public education that emphasizes special education and related services designed to meet the pupil's unique educational needs.[1] The mechanism for providing special education services under federal law is the individualized education program, or IEP. An IEP is a written statement developed after an evaluation of the pupil in all areas of suspected disability and may provide for related services including mental health and psychological services.[2]

Before the enactment of the test claim legislation, the state adopted a plan to comply with federal law. The responsibility for supervising special education and related services was delegated to the Superintendent of Public Instruction. Local educational agencies (LEAs) were financially responsible for the provision of mental health services required by a pupil's IEP.[3]

The test claim legislation, which became effective on July 1, 1986, shifted the responsibility and funding of mental health services required by a pupil's IEP to county mental health departments.

The Commission approved the test claim and found that the activities of providing mental health assessments, participation in the IEP process, psychotherapy, and other mental health services were reimbursable under article XIII B, section 6 of the California Constitution. Activities related to assessments and IEP responsibilities were found to be 100% reimbursable. Psychotherapy and other mental health treatment services were found to be 10% reimbursable due to the funding methodology in existence under the Short-Doyle Act for local mental health services.

The parameters and guidelines for *Handicapped and Disabled Students* (CSM 4282) were adopted in August 1991, and amended in 1996, and have a reimbursement period beginning July 1, 1986. The parameters and guidelines authorize reimbursement for the following activities:

A. One Hundred (100) percent of any costs related to IEP Participation, Assessment, and Case Management:

    1. The scope of the mandate is one hundred (100) percent reimbursement, except that for individuals billed to Medi-Cal only, the Federal Financing

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[1] See federal Rehabilitation Act of 1973 and the Individuals with Disabilities Education Act (IDEA).

[2] Title 20 United States Code sections 1400 et seq.

[3] Education Code sections 56000 et seq.

Participation portion (FFP) for these activities should be deducted from reimbursable activities not subject to the Short-Doyle Act.

2. For each eligible claimant, the following cost items are one hundred (100) percent reimbursable (Gov. Code, § 7572, subd. (d)(1)):

   a. Whenever an LEA refers an individual suspected of being an "individual with exceptional needs" to the local mental health department, mental health assessment and recommendation by qualified mental health professionals in conformance with assessment procedures set forth in Article 2 (commencing with section 56320) of Chapter 4 of part 30 of Division 4 of the Education Code, and regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, including but not limited to the following mandated services:

      i. interview with the child and family,

      ii. collateral interviews, as necessary,

      iii. review of the records,

      iv. observation of the child at school, and

      v. psychological testing and/or psychiatric assessment, as necessary.

   b. Review and discussion of mental health assessment and recommendation with parent and appropriate IEP team members. (Gov. Code, § 7572, subd. (d)(1).)

   c. Attendance by the mental health professional who conducted the assessment at IEP meetings, when requested. (Gov. Code, § 7572, subd. (d)(1).)

   d. Review by claimant's mental health professional of any independent assessment(s) submitted by the IEP team. (Gov. Code, § 7572, subd. (d)(2).)

   e. When the written mental health assessment report provided by the local mental health program determines that an "individual with special needs" is "seriously emotionally disturbed," and any member of the IEP team recommends residential placement based upon relevant assessment information, inclusion of the claimant's mental health professional on that individual's expanded IEP team.

   f. When the IEP prescribes residential placement for an "individual with exceptional needs" who is "seriously emotionally disturbed," claimant's mental health personnel's identification of out-of-home placement, case management, six month review of IEP, and expanded IEP responsibilities. (Gov. Code, § 7572.5.)

   g. Required participation in due process hearings, including but not limited to due process hearings.

3. One hundred (100) percent of any administrative costs related to IEP Participation, Assessment, and Case Management, whether direct or indirect.

B. Ten (10) percent of any costs related to mental health treatment services rendered under the Short-Doyle Act:

1. The scope of the mandate is ten (10) percent reimbursement.

2. For each eligible claimant, the following cost items, for the provision of mental health services when required by a child's individualized education program, are ten (10) percent reimbursable (Gov. Code, § 7576):

   a. Individual therapy,

   b. Collateral therapy and contacts,

   c. Group therapy,

   d. Day treatment, and

   e. Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.

3. Ten (10) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

In 1993, the Sixth District Court of Appeal, in *County of Santa Clara v. Commission on State Mandates*, issued an unpublished decision that upheld the Commission's decision, including the percentage of reimbursements, on the *Handicapped and Disabled Students* program.[4]

In May 2000, the Commission approved a second test claim relating to the test claim legislation, *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (CSM 97-TC-05). The test claim on *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05) was filed on Government Code section 7576, as amended by Statutes 1996, chapter 654, the corresponding regulations, and on a Department of Mental Health Information Notice Number 86-29. The test claim in *Seriously Emotionally Disturbed Pupils* addressed only the counties' responsibilities for *out-of-state* residential placements for seriously emotionally disturbed pupils, and has a reimbursement period beginning January 1, 1997.

In addition, there are two other matters currently pending with the Commission relating to the test claim legislation. In 2001, the Counties of Los Angeles and Stanislaus filed requests to amend the parameters and guidelines on the original test claim decision, *Handicapped and Disabled Students* (CSM 4282). The counties request that the parameters and guidelines be amended to delete all references to the Short-Doyle cost-sharing mechanism for providing psychotherapy or other mental health services; to add

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[4] *County of Santa Clara v. Commission on State Mandates*, Sixth District Court of Appeal Case No. H009520, filed January 11, 1993.

an activity to provide reimbursement for room and board for in-state placement of pupils in residential facilities; and to amend the language regarding the reimbursement of indirect costs. The request to amend the parameters and guidelines was scheduled on the Commission's March 2002 hearing calendar. But at the request of the counties, the item was taken off calendar, and is still pending. If the Commission approves the Counties' requests on this matter, the reimbursement period for the new amended portions of the parameters and guidelines would begin on July 1, 2000.[5]

The second matter currently pending with the Commission is a consolidated test claim, *Handicapped and Disabled Students II* (02-TC-40 and 02-TC-49), filed by the Counties of Los Angeles and Stanislaus on all of the amendments to the original test claim legislation from 1986 to the present. The test claims in *Handicapped and Disabled Students II* were filed in June 2003 and, if approved by the Commission, will have a reimbursement period beginning July 1, 2001.

<u>Documented Problems with the Test Claim Legislation</u>

There have been funding and implementation problems with this program, which have been well documented. In 2002, the Legislative Analyst's Office issued a budget analysis that described "significant controversy" regarding the program. The report states in relevant part the following:

> Over the last two years, the State Controller's Office (SCO) has audited county AB 3632 mandate reimbursement claims dating back to 1997 (three years of claims for each audited county). Based on information provided by counties and professional mandate claim preparers, we understand that SCO auditors have found that many counties are claiming reimbursements for 100 percent of the cost of providing mental health treatment services to special education pupils, rather than the 10 percent specified under the terms of this mandate. In addition, some counties are not reporting revenues that auditors indicate should be included as mandate cost "offsets." The magnitude of these auditing concerns is unknown, but could total as much as $100 million statewide for the three-year period.[6]

Before the audits could be completed, Statutes 2002, chapter 1167, section 41 (Assem. Bill No. 2851) was enacted directing the State Controller's Office to not dispute the percentage of reimbursement claimed for mental health services provided by counties prior to and through fiscal years 2000-2001. According to the State Controller's Office, however, audits continue for this program to identify unallowable costs. To date,

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[5] California Code of Regulations, title 2, section 1183.2.

[6] Report by Legislative Analyst's Office, *2002 Budget Analysis: Health and Social Services, Department of Mental Health (4440)*, dated February 20, 2002. The *Handicapped and Disabled Students* program is often referred to as the "AB 3632" program.

seventeen audits have been completed, three final reports are in the process, and five audits are in the fieldwork stage.[7]

In addition, the legislative history of SB 1895 refers to a report issued by Stanford Law School in May 2004 on the program that describes the history of the test claim legislation, and addresses the policy and funding issues.[8] According to legislative history, SB 1895 was an attempt to address the issues and recommendations raised in the report.[9]

Accordingly, this reconsideration presents the following issues:

- What is the scope of the Commission's jurisdiction directed by SB 1895?
- Does the test claim legislation constitute a state-mandated new program or higher level of service?
- Does the test claim legislation impose costs mandated by the state within the meaning of article XIII B, section 6 and Government Code section 17514?

Discussion

The courts have found that article XIII B, section 6 of the California Constitution[10] recognizes the state constitutional restrictions on the powers of local government to tax and spend.[11] "Its purpose is to preclude the state from shifting financial responsibility for carrying out governmental functions to local agencies, which are 'ill equipped' to assume increased financial responsibilities because of the taxing and spending limitations that articles XIII A and XIII B impose."[12] A test claim statute or executive order may impose a reimbursable state-mandated program if it orders or commands a local agency or school

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[7] E-mail from State Controller's Office dated January 19, 2005.

[8] The report is entitled "Challenge and Opportunity – An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California," Youth and Education Law Clinic, Stanford Law School, May 2004.

[9] Assembly Committee on Education, analysis of SB 1895 as introduced on March 3, 2004, dated June 23, 2004.

[10] Article XIII B, section 6, subdivision (a), (as amended by Proposition 1A in November 2004) provides: "(a) Whenever the Legislature or any state agency mandates a new program or higher level of service on any local government, the State shall provide a subvention of funds to reimburse that local government for the costs of the program or increased level of service, except that the Legislature may, but need not, provide a subvention of funds for the following mandates: (1) Legislative mandates requested by the local agency affected. (2) Legislation defining a new crime or changing an existing definition of a crime. (3) Legislative mandates enacted prior to January 1, 1975, or executive orders or regulations initially implementing legislation enacted prior to January 1, 1975."

[11] *Department of Finance v. Commission on State Mandates (Kern High School Dist.)* (2003) 30 Cal.4th 727, 735.

[12] *County of San Diego v. State of California* (1997) 15 Cal.4th 68, 81.

district to engage in an activity or task.[13] In addition, the required activity or task must be new, constituting a "new program," or it must create a "higher level of service" over the previously required level of service.[14]

The courts have defined a "program" subject to article XIII B, section 6, of the California Constitution, as one that carries out the governmental function of providing public services, or a law that imposes unique requirements on local agencies or school districts to implement a state policy, but does not apply generally to all residents and entities in the state.[15] To determine if the program is new or imposes a higher level of service, the test claim legislation must be compared with the legal requirements in effect immediately before the enactment of the test claim legislation.[16] A "higher level of service" occurs when the new "requirements were intended to provide an enhanced service to the public."[17]

Finally, the newly required activity or increased level of service must impose costs mandated by the state.[18] -

The Commission is vested with exclusive authority to adjudicate disputes over the existence of state-mandated programs within the meaning of article XIII B, section 6.[19] In making its decisions, the Commission must strictly construe article XIII B, section 6 and not apply it as an "equitable remedy to cure the perceived unfairness resulting from political decisions on funding priorities."[20]

I. What is the scope of the Commission's jurisdiction directed by SB 1895?

Statutes 2004, chapter 493, section 7 (Sen. Bill No. 1895, eff. Sept. 13, 2004), requires the Commission on State Mandates, on or before December 31, 2005, "notwithstanding

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[13] *Long Beach Unified School Dist. v. State of California* (1990) 225 Cal.App.3d 155, 174.

[14] *San Diego Unified School Dist. v. Commission on State Mandates* (2004) 33 Cal.4th 859, 878 (*San Diego Unified School Dist.)*; *Lucia Mar Unified School District v. Honig* (1988) 44 Cal.3d 830, 835-836 (*Lucia Mar*).

[15] *San Diego Unified School Dist., supra,* 33 Cal.4th 859, 874, (reaffirming the test set out in *County of Los Angeles v. State of California* (1987) 43 Cal.3d 46, 56; *Lucia Mar, supra,* 44 Cal.3d 830, 835.)

[16] *San Diego Unified School Dist., supra,* 33 Cal.4th 859, 878; *Lucia Mar, supra*, 44 Cal.3d 830, 835.

[17] *San Diego Unified School Dist., supra,* 33 Cal.4th 859, 878.

[18] *County of Fresno v. State of California* (1991) 53 Cal.3d 482, 487; *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1265, 1284 (*County of Sonoma*); Government Code sections 17514 and 17556.

[19] *Kinlaw v. State of California* (1991) 54 Cal.3d 326, 331-334; Government Code sections 17551, 17552.

[20] *County of Sonoma, supra,* 84 Cal.App.4th 1265, 1280, citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

any other law" to "reconsider its decision relating to included services and administrative and travel costs associated with services provided pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and the parameters and guidelines for calculating the state reimbursements for these costs."

As described in the Background, the Commission has issued two decisions relating to Chapter 26.5 of the Government Code. The first decision, *Handicapped and Disabled Students* (CSM 4282), was adopted on April 26, 1990. The test claim on *Handicapped and Disabled Students* (CSM 4282) was filed on Government Code section 7570 and following, as added and amended by Statutes 1984, chapter 1747, and Statutes 1985, chapter 1274, and on California Administrative Code, title 2, division 9, sections 60000-60610 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and re-filed June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)).

The second decision, *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05), was adopted on May 25, 2000. The test claim on *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05) was filed on Government Code section 7576, as amended by Statutes 1996, chapter 654, the corresponding regulations, and on a Department of Mental Health Information Notice Number 86-29. The test claim in *Seriously Emotionally Disturbed Pupils* addressed only the counties' responsibilities for *out-of-state* residential placements for seriously emotionally disturbed pupils. This test claim did not address the mental health services provided by counties to pupils in the state of California.

A third test claim is pending with the Commission, *Handicapped and Disabled Students II* (02-TC-40 and 02-TC-49), and has been filed by the Counties of Los Angeles and Stanislaus on all of the amendments to the statutes in Chapter 26.5 of the Government Code and to their corresponding regulations from 1986 up to the current date. The test claims in *Handicapped and Disabled Students II* were filed in June 2003 and, if approved by the Commission, will have a reimbursement period beginning July 1, 2001.

For purposes of this reconsideration, the Counties of Los Angeles and Stanislaus contend that SB 1895 requires the Commission to reconsider not only the Commission's original decision in *Handicapped and Disabled Students* (CSM 4282), but also on *all* the subsequent amendments to the statutes and regulations up to the current date that were pled in *Handicapped and Disabled 11*. In this regard, the County of Stanislaus argues that "to reconsider the prior test claim only, without examining that which has amended the program since its original inception in 1984, overlooks 20 years of subsequent legislation and which has lead to the substantial filings which are before the Commission on State Mandates."[21] The Counties further contend that SB 1895 requires the Commission to reconsider the Commission's decision in *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05), adopted on May 25, 2000.

[21] Comments filed by County of Stanislaus on December 15, 2004.

Although the Counties' arguments to analyze Chapter 26.5 of the Government Code in its entirety up to the current date for purposes of reimbursement may have surface appeal, neither the law, nor the plain language of SB 1895 supports that position. For the reasons provided below, the Commission finds that SB 1895 gives the Commission the jurisdiction to reconsider only the original Commission decision, *Handicapped and Disabled Students* (CSM 4282). The Commission does not have the jurisdiction in this case to reconsider *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05), or the jurisdiction to address the statutory and regulatory amendments made to the program since 1985 that have been pled in *Handicapped and Disabled Students II* (02-TC-40 and 02-TC-49). The Commission further finds, based on the language of SB 1895, that the period of reimbursement for the Commission's decision on reconsideration begins July 1, 2004.

A. SB 1895 directs the Commission to reconsider only the original Commission decision, *Handicapped and Disabled Students* (CSM 4282)

It is a well-settled issue of law that administrative agencies, such as the Commission, are entities of limited jurisdiction. Administrative agencies have only the powers that have been conferred on them, expressly or by implication, by statute or constitution. An administrative agency may not substitute its judgment for that of the Legislature. When an administrative agency acts in excess of the powers conferred upon it by statute or constitution, its action is void.[22]

Since the Commission was created by the Legislature (Gov. Code, §§ 17500 et seq.), its powers are limited to those authorized by statute. Government Code section 17551 requires the Commission to hear and decide upon a claim by a local agency or school district that the local agency or school district is entitled to reimbursement pursuant to article XIII B, section 6 of the California Constitution. Government Code section 17521 defines the test claim as the first claim filed with the Commission alleging that a particular statute or executive order imposes costs mandated by the state.

Thus, the Government Code gives the Commission jurisdiction only over those statutes and/or executive orders pled by the claimant in the test claim. The Commission does not have the authority to consider a claim for reimbursement on statutes or executive orders that have not been pled by the claimant.

In addition, if the Commission approves the test claim, the period of reimbursement is calculated based on the date the test claim is filed by the claimant. Government Code section 17557, subdivision (e), states "[a] test claim shall be submitted on or before June 30 following a fiscal year in order to establish eligibility for reimbursement for that fiscal year." Thus, if a test claim is filed on June 30, 2004, and is approved by the Commission, the reimbursement period would begin in fiscal year 2002-2003. Reimbursement is not based on the effective and operative date of the particular statute or executive order pled in the test claim, unless the effective and operative date falls after the period of reimbursement.

[22] *Ferdig v. State Personnel Board* (1969) 71 Cal.2d 96, 103-104.

Furthermore, Government Code section 17559 grants the Commission the authority to reconsider prior final decisions only within 30 days after the Statement of Decision is issued.

In the present case, the Commission's jurisdiction is based solely on SB 1895. Absent SB 1895, the Commission would have no jurisdiction to reconsider any of its decisions relating to Chapter 26.5 of the Government Code since the two decisions on those statutes and regulations were adopted and issued well over 30 days ago.

Thus, the Commission must act within the jurisdiction granted by SB 1895, and may not substitute its judgment regarding the scope of its jurisdiction on reconsideration for that of the Legislature.[23] Since an action by the Commission is void if its action is in excess of the powers conferred by statute, the Commission must narrowly construe the provisions of SB 1895.

Under the rules of statutory construction, when the statutory language is plain the court is required to enforce the statute according to its terms. The California Supreme Court determined that:

> In statutory construction cases, our fundamental task is to ascertain the intent of the lawmakers so as to effectuate the purpose of the statute. We begin by examining the statutory language, giving the words their usual and ordinary meaning. If the terms of the statute are unambiguous, we presume the lawmakers meant what they said, and the plain meaning of the language governs. [Citations omitted.][24]

Neither the court, nor the Commission, may disregard or enlarge the plain provisions of a statute or go beyond the meaning of the words used when the words are clear and unambiguous. Thus, the Commission, like the court, is prohibited from writing into a statute, by implication, express requirements that the Legislature itself has not seen fit to place in the statute.[25] To the extent there is any ambiguity in the language used in the statute, the legislative history of the statute may be reviewed to interpret the intent of the Legislature.[26]

SB 1895 states the following:

> Notwithstanding any other law, the Commission on State Mandates shall, on or before December 31, 2005, reconsider its decision relating to included services and administrative and travel costs associated with services provided pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and the parameters and guidelines for calculating the state reimbursements for these costs.

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[23] *Cal. State Restaurant Assn. v. Whitlow* (1976) 58 Cal.App.3d 340, 346-347.

[24] *Estate of Griswald* (2001) 25 Cal.4th 904, 910-911.

[25] *Whitcomb v. California Employment Commission* (1944) 24 Cal.2d 753, 757.

[26] *Estate of Griswald, supra*, 25 Cal.4th at page 911.

First, the Commission does not have the jurisdiction to "reconsider" the statutory and regulatory amendments enacted after 1985 to the Handicapped and Disabled program that were pled in *Handicapped and Disabled Students II* (02-TC-40 and 02-TC-49) since the Commission has not yet adopted a decision on that claim. Pursuant to Government Code section 17557, subdivision (e), *Handicapped and Disabled Students II* will have a reimbursement period beginning July 1, 2001, if the Commission finds that the statutory and regulatory amendments pled in the claim constitute a reimbursable state-mandated program.

Second, the Commission finds that the Commission does not have the jurisdiction to reconsider the Commission's decision in *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05). The express language enacted by the Legislature in SB 1895 refers to one decision with the use of the singular word "decision." According to the analysis on the bill prepared by the Senate Rules Committee dated August 25, 2004, SB 1895 "[d]irects the Commission on State Mandates (CSM), on or before December 31, 2005, to reconsider its decision relating to administrative and travel costs for AB 3632 (Brown), Chapter 1747, Statutes of 1984 and its parameters and guidelines for calculating state reimbursement costs." The legislative history cites only to the author and one of the statutes pled in the original *Handicapped and Disabled Students* (CSM 4282) test claim. Although, as argued by the Counties, the statutes pled in *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05) are included in Chapter 26.5 of the Government Code, there is no indication in the plain language of SB 1895 or in the Senate Rules Committee analysis that the Legislature intended to give the Commission jurisdiction to reconsider *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05). The SEDs test claim was filed on a 1996 statute (Assem. Bill 2726), introduced by another author who is not identified in SB 1895 or in the legislative history.[27]

Therefore, the Commission finds that the Commission has jurisdiction to reconsider only the original Commission decision, *Handicapped and Disabled Students* (CSM 4282).

Finally, SB 1895 directs the Commission to reconsider its decision relating to "*included services* and administrative and travel costs" associated with services provided pursuant to Chapter 26.5 of the Government Code. The phrase "included services" is broad and does not limit the scope of this reconsideration to any particular service required by the statutes or regulations pled in *Handicapped and Disabled Students*. Therefore, the Commission finds that SB 1895 requires the Commission to reconsider the entire test claim in *Handicapped and Disabled Students*.

B. The period of reimbursement for the Commission's decision on reconsideration begins July 1, 2004

SB 1895, enacted as a 2004 statute, directs the Commission to reconsider its 1990 Statement of Decision on the *Handicapped and Disabled Students* program. The parameters and guidelines for this program were originally adopted in 1991, with a reimbursement period beginning July 1, 1986. Over the last 14 years, reimbursement

[27] Statutes 1996, chapter 654 was introduced by Assembly Member Woods.

claims have been filed with the State Controller's Office for payment on this program, payments have been made by the state, and audits have occurred.

SB 1895, however, does not specify the period of reimbursement for the Commission's decision on reconsideration.[28] The question is whether the Legislature intended to apply the Commission's decision on reconsideration retroactively back to the original reimbursement period of July 1, 1986 (i.e., to reimbursement claims that have already been filed and have been audited and/or paid), or to prospective claims filed in the current and future budget years. If the Commission's decision on reconsideration is applied retroactively, the decision may impose new liability on the state that did not otherwise exist or change the legal consequences of these past events.

For the reasons below, the Commission finds the Legislature intended that the Commission's decision on reconsideration apply prospectively, to current and future budget years only.

The California Supreme Court has recently upheld its conclusion that there is a strong presumption against retroactive legislation. Statutes generally operate prospectively only. A statute may be applied retroactively only if the statute contains "express language of retroactively [sic] or if other sources provide a clear and unavoidable implication that the Legislature intended retroactive application."[29] The court explained its conclusion as follows:

> "Generally, statutes operate prospectively only." [Citation omitted.] "The presumption against retroactive legislation is deeply rooted in our jurisprudence, and embodies a legal doctrine centuries older than our Republic. Elementary considerations of fairness dictate that individuals should have an opportunity to know what the law is and to conform their conduct accordingly … For that reason, the "principle that the legal effect of conduct should ordinarily be assessed under the law that existed when the conduct took place has timeless and universal appeal." [Citation omitted.] "The presumption against statutory retroactivity has consistently been explained by reference to the unfairness of imposing new burdens on persons after the fact." [Citation omitted.]
>
> This is not to say that a statute may never apply retroactively. "A statute's retroactivity is, *in the first instance, a policy determination for the Legislature* and one to which courts defer absent 'some constitutional objection' to retroactivity." [Citation omitted.] But it has long been established that a statute that interferes with antecedent rights will not operate retroactively unless such retroactivity be "the unequivocal and

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[28] In this respect, SB 1895 is different than another recent statute directing the Commission to reconsider a prior final decision. Statutes 2004, chapter 227, directs the Commission to reconsider Board of Control test claims relating to regional housing. Section 109 of the bill states "[a]ny changes by the commission shall be deemed effective July 1, 2004."

[29] *McClung v. Employment Development Department* (2004) 34 Cal.4th 467, 475.

> inflexible import of the terms, and the manifest intention of the legislature." [Citation omitted.] "*A statute may be applied retroactively only if it contains express language of retroactively [sic] or if other sources provide a clear and unavoidable implication that the Legislature intended retroactive application*." [Citation omitted.] (Emphasis added.)[30]

There is nothing in the plain language of SB 1895 or its legislative history to suggest that the Legislature intended to apply the Commission's decision on reconsideration retroactively. Section 10 of SB 1895 states that the act was necessary to implement the Budget Act of 2004 and, thus, supports the conclusion that the statute was intended to apply prospectively to the current and future budget years. Similarly, the legislative history contained in the analysis of the Senate Rules Committee supports the conclusion that the statute applies to current and future budget years only. Page seven of the analysis states that "[t]his bill proposes to provide clarification and accountability *regarding the funds provided in the 2004-05 Budget Act* for mental health services for individuals with special needs." (Emphasis added.)

Moreover, had the Legislature intended to apply the Commission's decision on reconsideration retroactively, it would have included retroactive language in the bill similar to the language in other statutes relating to this program. For example, Statutes 2002, chapter 1167, addressed the funding and reimbursement for the Handicapped and Disabled program. The effective and operative date of the statute was September 30, 2002. However, the plain language in section 38 of the bill contains retroactive language that the terms of the statute applied to reimbursement claims for services delivered beginning in fiscal year 2001-2002. Section 41 of the bill also states that county reimbursement claims already submitted to the Controller for reimbursement for mental health treatment services in fiscal years up to and including fiscal year 2000-2001 were not subject to a dispute by the Controller's Office regarding the percentage of reimbursement claimed by the county.

Based on the case law cited above and the plain language of SB 1895, the Commission finds that the period of reimbursement for the Commission's decision on reconsideration begins July 1, 2004. Thus, to the extent there are new activities included in the program that are now reimbursable, reimbursement would begin July 1, 2004.

II. Does the test claim legislation constitute a state-mandated new program or higher level of service?

At the hearing, the Department of Finance argued that the state has chosen to make mental health services related to IEPs the responsibility of the counties and that current federal law allows the state to choose the agency or agencies responsible for service. Thus, the Department of Finance contends that the activities performed by counties under the Handicapped and Disabled Students program are federally mandated and not mandated by the state within the meaning of article XIII B, section 6 of the California Constitution. The Commission disagrees with the Department of Finance.

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[30] *Ibid.*

In 1993, the Sixth District Court of Appeal, in *County of Santa Clara v. State of California*, issued an unpublished decision in the present case upholding the Commission's decision that the test claim legislation constitutes a reimbursable state-mandated program pursuant to article XIII B, section 6 of the California Constitution.[31] Once a court has ruled on a question of law in its review of an agency's action, the agency cannot act inconsistently with the court's order. Instead, absent "unusual circumstances," or an intervening change in the law, the decision of the reviewing court establishes the law of the case and binds the agency and the parties to the action in all further proceedings addressing the particular claim.[32]

Although there have been subsequent amendments to the original test claim legislation that have provided more specificity in the activities performed by counties and that have modified financial responsibilities for the Handicapped and Disabled program, these amendments do not create an "unusual circumstance" or constitute an "intervening change in the law" that would support a finding on reconsideration that the test claim should be denied.[33]

Although the Commission finds that the activities identified in the original Statement of Decision and the financial responsibilities for the program should be further clarified on reconsideration, the decision in *County of Santa Clara* that the test claim legislation is a reimbursable state-mandated program, is binding on the Commission and the parties for purposes of this reconsideration.

Moreover, other case law interpreting article XIII B, section 6, which is described below, further supports the conclusion that the test claim legislation mandates a new program or higher level of service on counties.

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[31] *County of Santa Clara v. Commission on State Mandates*, Sixth District Court of Appeal Case No. H009520, filed January 11, 1993. The court stated the following:

> The intent of section 6 was to preclude the state from shifting to local government the financial responsibility for providing services in light of the restrictions imposed by Proposition 13 on the taxing and spending powers of local government. (*Lucia Mar Unified School Dist. v. Honig* (1988) 44 Cal.3d 830, 835-836.) Here it is undisputed that the provision of psychotherapy and other mental health services to special education students resulted in a higher level of service within County's Short-Doyle program.

[32] *George Arakelian Farms, Inc. v. Agricultural Labor Relations Board* (1989) 49 Cal.3d 1279, 1291.

[33] The amendments addressing financial responsibilities for this program are included in this analysis. The amendments enacted after 1985 that modify the activities performed by counties, however, are addressed in the *Handicapped and Disabled Students II* test claim filed by the Counties of Los Angeles and Stanislaus (02-TC-40 and 02-TC-49).

A. Case law supports the conclusion that the test claim legislation mandates a new program or higher level of service

The test claim legislation implements federal law that requires states to guarantee to disabled pupils the right to receive a free and appropriate public education that emphasizes special education and related services designed to meet the pupil's unique educational needs.

In 1988, the California Supreme Court held that education of handicapped children is "clearly" a governmental function providing a service to the public.[34] Thus, the test claim legislation qualifies as a program that is subject to article XIII B, section 6 of the California Constitution.

In 1992, the Third District Court of Appeal, in *Hayes v. Commission on State Mandates*, determined that the federal law at issue in the present case imposes a federal mandate on the states.[35] The *Hayes* case involved test claim legislation requiring school districts to provide special education services to disabled pupils. The school districts in the *Hayes* case alleged that the activities mandated by the state that exceeded federal law were reimbursable under article XIII B, section 6 of the California Constitution.

The court in *Hayes* determined that the state's "alternatives [with respect to federal law] were to participate in the federal program and obtain federal financial assistance and the procedural protections accorded by the act, or to decline to participate and face a barrage of litigation with no real defense and ultimately be compelled to accommodate the educational needs of handicapped children in any event."[36] The court concluded that the state had no "true choice" but to participate in the federal program and, thus, there was a federal mandate on the state.[37]

Although the court concluded that the federal law was a mandate on the states, the court remanded the case to the Commission for further findings to determine if the state's response to the federal mandate constituted a state-mandated new program or higher level of service on the school districts.[38] The court held as follows:

> In our view the determination whether certain costs were imposed upon the local agency by a federal mandate must focus upon the local agency which is ultimately forced to bear the costs and how those costs came to be imposed upon that agency. If the state freely chose to impose the costs upon the local agency as a means of implementing a federal program then the costs are the result of a reimbursable state mandate regardless whether the costs were imposed upon the state by the federal government.[39]

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[34] *Lucia Mar Unified School District, supra*, 44 Cal.3d at page 835.

[35] *Hayes v. Commission on State Mandates* (1992) 11 Cal.App.4th 1564, 1592.

[36] *Hayes, supra*, 11 Cal.App.4th at page 1591.

[37] *Ibid*.

[38] *Ibid*.

[39] *Id.* at pages 1593-1594.

The court described its conclusion as follows:

> The Education of the Handicapped Act [renamed IDEA] is a comprehensive measure designed to provide all handicapped children with basic educational opportunities. While the act includes certain substantive and procedural requirements which must be included in the state's plan for implementation of the act, it leaves primary responsibility for implementation to the state. (20 U.S.C. §§ 1412, 1413.) In short, even though the state had no real choice in deciding whether to comply with the federal act, the act did not necessarily require the state to impose all of the costs of implementation upon local school districts. To the extent the state implemented the act by freely choosing to impose new programs or higher levels of service upon local school districts, the costs of such programs or higher levels of service are state mandated and subject to subvention.[40]

The federal law relevant to this case is summarized on pages 1582-1594 of the *Hayes* decision, and its requirements that existed at the time the test claim legislation was enacted are described below.

1. Pursuant to the court's ruling in *Hayes*, federal special education law imposes a federal mandate on the state

Before the mid-1970s, a series of landmark court cases established the right to an equal educational opportunity for children with disabilities. The federal courts determined that children with disabilities were entitled to a free public program of education and training appropriate to the child's capacity and that the children and their parents were entitled to a due process hearing when dissatisfied with placement decisions.[41]

In 1973, Congress responded with the Rehabilitation Act of 1973, section 504. Section 504 of the Rehabilitation Act of 1973 imposes an obligation on local school districts to accommodate the needs of children with disabilities. Section 504 provides that "[n]o otherwise qualified handicapped individual in the United States, as defined in section 706(7) [now 706(8)] of this title, shall solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . ." (29 U.S.C. 794.) "Since federal assistance to education is pervasive, ... section 504 was applicable to virtually all public educational programs in this and other states."[42] Section 504 gives school districts "the duty of analyzing individually the needs of each handicapped student and devising a program which will enable each individual handicapped student to receive an appropriate, free public education. The failure to perform this analysis and structure a program suited to the needs of each handicapped

[40] *Id*. at page 1594.

[41] *Id.* at pages 1582-1584.

[42] *Id.* at page 1584.

child, constitutes discrimination against that child and a failure to provide an appropriate, free public education for the handicapped child."[43]

In 1974, Congress became dissatisfied with the progress under earlier efforts to stimulate the states to accommodate the educational needs of children with disabilities. Thus, in 1975, Congress enacted the Education for All Handicapped Children Act. In 1990, the Education for All Handicapped Act was renamed the Individuals with Disabilities Education Act (IDEA).[44]

Since 1975, the IDEA has guaranteed to disabled children the right to receive a free appropriate public education that emphasizes special education and related services designed to meet the child's individual needs. The IDEA further guarantees that the rights of disabled children and their parents are protected.[45] States are eligible for "substantial federal financial assistance" under the IDEA when the state agrees to adhere to the substantive and procedural terms of the act and submits a plan specifying how it will comply with federal requirements.[46] At the time the test claim legislation was enacted, the requirements of the IDEA applied to each state and each political subdivision of the state "involved in the education of handicapped children."[47]

Special education is defined under the IDEA as "specially designed instruction, at no cost to parents or guardians, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions.[48] To be eligible for services under the IDEA, a child must be between the ages of three and twenty-one and have a qualifying disability.[49] If it is suspected that a pupil has a qualifying disability, the Individual Education Program, or IEP, process begins. The IEP is a written statement for a handicapped child that is developed and implemented in accordance with federal IEP regulations.[50] Pursuant to federal regulations on the IEP process, the child must be evaluated in all areas of suspected handicaps by a multidisciplinary team. Parents also have the right to obtain an independent assessment of the child by a qualified professional. Local educational

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[43] *Id.* at pages 1584-1585.

[44] Public Law 101-476 (Oct. 30, 1990), 104 Stat.1143.

[45] 20 United States Code section 1400(c).

[46] *Hayes, supra,* 11 Cal.App.4th at page 1588; 20 United States Code sections 1411, 1412.

[47] Title 34 Code of Federal Regulations, sections 300.2 and 300.11. These regulations defined "public agency" to mean "all political subdivisions of the State *that are involved in the education of handicapped children*."

[48] Former Title 20 United States Code section 1401(a)(16). The definition can now be found in Title 20 United States Code section 1401(25).

[49] Title 20 United States Code section 1412.

[50] Title 20 United States Code section 1401; Title 34 Code of Federal Regulations section 300.340 et seq.

agencies are required to consider the independent assessment as part of their educational planning for the child.[51]

If it is determined that the child is handicapped within the meaning of IDEA, an IEP meeting must take place. Participants at the IEP meeting include a representative of the local educational agency, the child's teacher, one or both of the parents, the child if appropriate, other individuals at the discretion of the parent or agency, and evaluation personnel for children evaluated for the first time.[52] The local educational agency must take steps to insure that one or both of the parents are present at each meeting or are afforded the opportunity to participate, including giving the parents adequate and timely notice of the meeting, scheduling the meeting at a mutually convenient time, using other methods to insure parent participation if neither parent can attend, and taking whatever steps are necessary to insure that the parent understands the proceedings.[53] The IEP document must include the following information:

- a statement of the child's present levels of educational performance;
- a statement of annual goals, including short term instructional objectives;
- a statement of the specific special education and related services to be provided to the child, and the extent to which the child will be able to participate in regular educational programs;
- the projected dates for initiation of services and the anticipated duration of the services; and
- appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short term instructional objectives are being achieved.[54]

Each public agency must provide special education and related services to a handicapped child in accordance with the IEP.[55] In addition, each public agency must have an IEP in effect at the beginning of each school year for every handicapped child who is receiving special education from that agency. The IEP must be in effect before special education and related services are provided, and special education and related services set out in a child's IEP must be provided as soon as possible after the IEP is finalized.[56] Each public agency shall initiate and conduct IEP meetings to periodically review each child's IEP

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[51] Former Title 34 Code of Federal Regulations section 300.503. The requirement is now at Title 34 Code of Federal Regulation section 300.502.

[52] Title 34 Code of Federal Regulations section 300.344.

[53] Title 34 Code of Federal Regulations section 300.345.

[54] Former Title 34 Code of Federal Regulations section 300.346. The IEP requirements are now found in Title 34 Code of Federal Regulations section 300.347.

[55] Former Title 34 Code of Federal Regulations section 300.349. The requirement is now found in Title 34 Code of Federal Regulations section 300.343.

[56] Title 34 Code of Federal Regulations section 300.342.

and, if appropriate, revise its provisions. A meeting must be held for this purpose at least once a year.[57]

A child that is assessed during the IEP process as "seriously emotionally disturbed" has a qualifying disability under the IDEA.[58] "Seriously emotionally disturbed" children are children who have an inability to learn which cannot be explained by intellectual, sensory, or health factors; who are unable to build or maintain satisfactory interpersonal relationships with peers and teachers; who exhibit inappropriate types of behavior or feelings under normal circumstances; who have a general pervasive mood of unhappiness or depression; and/or who have a tendency to develop physical symptoms or fears associated with personal or school problems. One or more of these characteristics must be exhibited over a long period of time and to a marked degree, and must adversely affect educational performance in order for a child to be classified as "seriously emotionally disturbed." Schizophrenic children are included in the "seriously emotionally disturbed" category. Children who are socially maladjusted are not included unless they are otherwise determined to be emotionally disturbed.[59]

Related services designed to assist the handicapped child to benefit from special education are defined to include "transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children."[60] Federal regulations define "psychological services" to include the following:

- administering psychological and educational tests, and other assessment procedures;
- interpreting assessment results;
- obtaining, integrating, and interpreting information about child behavior and conditions relating to learning;

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[57] Title 34 Code of Federal Regulations section 300.343.

[58] Former Title 20 United States Code section 1401(a)(1). The phrase "serious emotionally disturbed" has been changed to "serious emotional disturbance." (See, 20 U.S.C. § 1401(3)(A)(i).)

[59] Former Title 34 Code of Federal Regulations section 300.5, subdivision (b)(8). "Serious emotional disturbance" is now defined in Title 34 Code of Federal Regulations section 300.7(c)(3).

[60] Title 20 United States Code section 1401; former Title 34 Code of Federal Regulations section 300.13 (the definition of "related services" can now be found in 34 C.F.R. § 300.24.)

- consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations; and
- planning and managing a program of psychological services, including psychological counseling for children and parents.[61]

The comments to section 300.13 of the federal regulations further state that “[t]he list of related services is not exhaustive and may include other developmental, corrective, or supportive services . . . if they are required to assist a handicapped child to benefit from special education.”

Furthermore, if placement in a public or private residential program is necessary to provide special education and related services to a handicapped child, the program, including non-medical care and room and board, must be at no cost to the parents or child.[62]

The IDEA also requires states and local educational agencies to establish and maintain due process procedures to assure that handicapped children and their parents are guaranteed procedural safeguards. The procedures must include an opportunity for the parents to examine all relevant records and to obtain an independent educational evaluation; procedures to protect the rights of children who do not have parents or guardians to assert their rights, including procedures for appointment of a surrogate for the parents; prior written notice to the parents whenever the educational agency proposes to initiate, change, or refuse to initiate or change the identification, evaluation or educational placement of the child or the provision of a free appropriate public education to the child; procedures designed to assure that the required notice fully informs the parents in the parents’ native language of all the procedures available; and an opportunity to present complaints. There must also be impartial due process hearing procedures that include the right to be accompanied and advised by counsel and by individuals with special knowledge or training with respect to the problems of handicapped children; the right to present evidence; the right to confront, cross-examine, and compel the attendance of witnesses; the right to a written or electronic verbatim record of the hearing; the right to written findings of fact and decisions; the right to appeal the determination of the due process hearing officer; and the right to bring a civil action in court. The court in its discretion may award attorney’s fees and costs in certain circumstances.[63]

Finally, the state is ultimately responsible for insuring the requirements of the IDEA. For example, the state educational agency is responsible for assuring that all education and related services required for a handicapped child will be under the general supervision of persons responsible for educational programs for handicapped children in the state educational agency and shall meet the education standards of the state educational

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[61] *Ibid.*

[62] Title 20 United States Code section 1412; Title 34 Code of Federal Regulations section 300.302.

[63] Title 20 United States Code 1415.

agency.[64] The state educational agency is responsible for insuring that each public agency develops and implements an IEP for each handicapped child.[65] Furthermore, the state educational agency must provide services directly if no other agency provides them.[66] The comments to section 300.600 of the federal regulations describe the purpose of making the states ultimately responsible for providing special education and related services:

> The requirement in § 300.600(a) is taken essentially verbatim from section 612(6) of the statute and reflects the desire of the Congress for a central point of responsibility and accountability in the education of handicapped children with each State. With respect to State educational agency responsibility, the Senate Report on Pub. L. 94-142 includes the following statements:
>
> This provision is included specifically to assure a single line of responsibility with regard to the education of handicapped children, and to assure that in the implementation of all provisions of this Act and in carrying out the right to education for handicapped children, the State educational agency shall be the responsible agency . . . .
>
> Without this requirement, there is an abdication of responsibility for the education of handicapped children. Presently, in many States, responsibility is divided, depending upon the age of the handicapped child, sources of funding, and type of services delivered. While the committee understands that different agencies may, in fact, deliver services, the responsibility must remain in a central agency overseeing the education of handicapped children, so that failure to deliver services or the violation of the rights of handicapped children is squarely the responsibility of one agency. (Sen. Rep. 94-168, p. 24 (1975)).

There have been several amendments to the IDEA since the test claim legislation was originally enacted in 1984. Congress' 1997 amendment to the IDEA is relevant for purposes of this action. In 1997, Congress amended the IDEA to "strengthen the requirements on ensuring provisions of services by non-educational agencies …" (Sen. Rep. 105-17, dated May 9, 1997.) The amendment clarified that the state or local educational agency responsible for developing a child's IEP could look to non-educational agencies to pay for or provide those services the educational agencies are otherwise responsible for. The amendment further clarified that if a non-educational agency failed to provide or pay for the special education and related services, the state or local educational agency responsible for developing the IEP remain ultimately responsible for ensuring that children receive all the services described in their IEPs in a

[64] Former Title 20 United States Code section 1412(6). The requirement is now in Title 20 United States Code section 1412(a)(11).

[65] Title 34 Code of Federal Regulations section 300.341.

[66] Former Title 34 Code of Federal Regulation section 300.600. The requirement is now in Title 34 Code of Federal Regulations section 300.142.

timely fashion and the state or local educational agency shall provide or pay for the services.[67] Federal law does not require states to use non-educational agencies to pay for or provide services. A states' decision regarding how to implement of the IDEA is still within the discretion of the state.

2. The state "freely chose" to mandate a new program or higher level of service on counties to implement the federal law

The court in *Hayes* held that if the state freely chose to impose the costs upon the local agency as a means of implementing a federally mandated program, regardless of whether the costs were imposed on the state by the federal government, then the costs are the result of a reimbursable state mandate pursuant to article XIII B, section 6.[68]

As more fully described below, the Commission finds that the state, with the enactment of the test claim legislation, freely chose to mandate a new program or higher level of service on counties.

The federal IDEA includes certain substantive and procedural requirements that must be included in the state's plan for implementation. But, as outlined above, federal law leaves the primary responsibility for implementation to the state.

Before the enactment of the test claim legislation, the state enacted comprehensive legislation (Ed. Code, §§ 56000 et seq.) to comply with federal law that required local educational agencies to provide special education services, including mental health and residential care services, to special education students.[69] Education Code section 56000 required that students receive public education and related services through the Master Plan for Special Education. Under the master plan, special education local plan areas (SELPAs), which consist of school districts and county offices of education, were responsible for developing and implementing a plan consistent with federal law to provide an appropriate education for individuals with special needs.[70] Each district, SELPA, or county office of education was required to establish IEP teams to develop, review, and revise education programs for each student with special needs.[71] The IEP team may determine that mental health or residential treatment services were required to support the student's special education needs.[72] The following mental health services were identified in statute: counseling and guidance; psychological services, other than assessment and development of the IEP; parent counseling and training; health and

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[67] Title 20 United States Code sections 1412 (a)(12)(A), (B), and (C), and 1401 (8); Title 34 Code of Federal Regulations section 300.142. (See also, Letters from the Department of Education dated July 28, 1998 and August 2, 2004, to all SELPAs, COEs, and LEAs on the requirements of 34 C.F.R. 300.142; and *Tri-County Special Education Local Plan Area v. County of Tuolumne* (2004) 123 Cal.App.4th 563, 578.)

[68] *Hayes, supra*, 11 Cal.App.4th at pages 1593-1594.

[69] Statutes 1980, chapter 1218.

[70] Education Code sections 56140 and 56200.

[71] Education Code sections 56340 and 56341.

[72] Education Code sections 56363 and 56365.

nursing services; and social worker services.[73] In such cases, the school districts and county offices of education were solely responsible for providing special education services, including mental health and residential care services, for special education students under the state's statutory scheme.[74] The state Superintendent of Public Instruction was, and still is, responsible for supervising education and related services for handicapped children pursuant to the IDEA.[75]

In 1984 and 1985, the Legislature enacted the test claim legislation, which added Chapter 26.5 to the Government Code to shift the responsibility and funding of mental health services required by a pupil's IEP to county mental health departments. Generally, the test claim legislation requires counties to:

- renew the interagency agreement with the local educational agency every three years and, if necessary, revise the agreement;
- perform an initial assessment of a pupil referred by the local educational agency, and discuss assessment results with the parents and IEP team;
- participate as a member of the IEP team whenever the assessment of a pupil determines the pupil is seriously emotionally disturbed and residential placement may be necessary;
- act as the lead case manager, as specified in statute and regulations, if the IEP calls for residential placement of a seriously emotionally disturbed pupil;
- issue payments to providers of out-of-home residential care for the residential and non-educational costs of seriously emotionally disturbed pupils;
- provide psychotherapy or other mental health services, as defined in regulations, when required by the IEP; and
- participate in due process hearings relating to issues involving mental health assessments or services.

The purpose of the test claim legislation was recently described in the report prepared by Stanford Law School as follows:

> With the passage of AB 3632, California's approach to mental health services was restructured with the intent to address the increasing number of emotionally disabled students who were in need of mental health services. Instead of relying on LEAs to acquire qualified staff to handle

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[73] Education Code section 56363.

[74] Education Code section 56363; see also, Report by the Office of the Auditor General, dated April 1987, entitled "A Review of the Costs of Providing Noneducational Services to Special Education Students." The report states that in fiscal year 1985-86, the year immediately before the effective date of the test claim legislation, local education agencies provided psychotherapy and other mental health services to 941 students and residential services to 225 students.

[75] Education Code section 56135 and Government Code section 7570.

> the needs of these students, the state sought to have CMH [county mental health] agencies – who were already in the business of providing mental health services to emotionally disturbed youth and adults – assume the responsibility for providing needed mental health services to children who qualified for special education. Moreover, it was believed at the time that such mental health services would be most cost-efficiently provided by CMH agencies.[76]

Federal law does not require the state to impose any requirements relating to special education and related services on counties. At the time the test claim legislation was enacted, the requirements under federal law were imposed only on states and local educational agencies.[77] Today, federal law authorizes, but does not require, states to shift some of the special education requirements to non-educational agencies, such as county mental health departments.[78] But, if a county does not provide the service, federal law requires the state educational agency to be ultimately responsible for providing the services directly.[79] Thus, the decision to shift the mental health services for special education pupils from schools to counties was a policy decision of the state.

Moreover, the mental health services required by the test claim legislation for special education pupils were new to counties. At the time the test claim legislation was enacted, the counties had the existing responsibility under the Short-Doyle Act to provide mental health services to eligible children and adults. (Welf. & Inst. Code, §§ 5600 et seq.) But as outlined in a 1997 report prepared by the Department of Mental Health and the Department of Education, the requirements of the test claim legislation are different than the requirements under the Short-Doyle program. For example, mental health services under the Short-Doyle program for children are provided until the age of 18, are provided year round, and the clients must pay the costs of the services based on the ability to pay. Under the special education requirements, mental health services may be provided until the pupil is 22 years of age, are generally provided during the school year, and must be provided at no cost to the parent. Furthermore, the definition of "serious emotional disturbance" as a disability requiring special education and related services focuses on the pupil's functioning in school, a standard that is different than the standard provided under the Short-Doyle program.[80] Thus, with the enactment of the test claim legislation,

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[76] "Challenge and Opportunity – An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California," Youth and Education Law Clinic, Stanford Law School, May 2004, page 12.

[77] Title 34 Code of Federal Regulations section 300.2.

[78] Title 20 United States Code section 1412(a)(12).

[79] Title 20 United States Code sections 1412(a)(12)(A), (B), and (C), and 1401(8); Title 34 Code of Federal Regulations section 300.142.

[80] "Mental Health Services for Special Education Pupils, A Report to the State Department of Mental Health and the California Department of Education," dated March 1997. The construction of statutes by the officials charged with its administration is entitled to great weight. (*Whitcomb, supra*, 24 Cal.2d at pp. 756-757.)

counties are now required to perform mental health activities under two separate and distinct provisions of law: the Government Code (the test claim legislation) and the Welfare and Institutions Code.

Since article XIII B, section 6 "was intended to preclude the state from shifting to local agencies the financial responsibility for providing public services in view of restrictions on the taxing and spending power of the local entities,"[81] the Commission finds that the shift of mental health services for special education pupils to counties constitutes a new program or higher level of service.

Accordingly, the Commission finds that the Commission's conclusion adopted in the 1990 Statement of Decision, that the test claim legislation mandates a new program or higher level of service, was correctly decided. The new activities mandated by the state are described below.

B. Activities expressly required by the test claim legislation that constitute a state-mandated new program or higher level of service on counties

The findings and conclusion in the Commission's 1990 Statement of Decision generally identify the following state-mandated activities: assessment, participation on the expanded IEP team, case management services for seriously emotionally disturbed pupils, and providing psychotherapy and other mental health services required by the pupil's IEP. The 1990 Statement of Decision states:

> The Commission concludes that, to the extent that the provisions of Government Code section 7572 and section 60040, Title 2, Code of California Regulations, require county participation in the mental health assessment for "individuals with exceptional needs," such legislation and regulations impose a new program or higher level of service upon a county.
>
> Moreover, the Commission concludes that any related participation on the expanded IEP team and case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed," pursuant to subdivisions (a), (b), and (c) of Government Code section 7572.5 and their implementing regulations, impose a new program or higher level of service upon a county. …
>
> The Commission concludes that the provisions of Welfare and Institutions Code section 5651, subdivision (g), result in a higher level of service within the county Short-Doyle program because the mental health services, pursuant to Government Code sections 7571 and 7576 and their implementing regulations, must be included in the county Short-Doyle annual plan. In addition, such services include psychotherapy and other mental health services provided to "individuals with exceptional needs," including those designated as "seriously emotionally disturbed," and required in such individual's IEP. …

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[81] *San Diego Unified School Dist., supra*, 33 Cal.4th at page 876.

As described below, the Commission finds that the 1990 Statement of Decision does not fully identify all of the activities mandated by the test claim legislation.

1. Renew the interagency agreement with the local educational agency every three years and, if necessary, revise the agreement (Gov. Code, § 7571; Cal Code Regs., tit. 2, §§ 60030, 60100)[82]

Government Code section 7571 requires the Secretary of Health and Welfare to designate a single agency in each county to coordinate the service responsibilities described in Government Code section 7572. To implement this requirement, section 60030 of the joint regulations adopted by the Department of Mental Health and the Department of Education (Cal. Code Regs., tit. 2, §§ 60000 et seq.) require the local mental health director to appoint a liaison person for the local mental health program to ensure that an interagency agreement is developed before July 1, 1986, with the county superintendent of schools.[83] The requirement to develop the initial interagency agreement before July 1, 1986 is not reimbursable because the original reimbursement period for this claim began on or after July 1, 1986, and the reimbursement period for purposes of this reconsideration is July 1, 2004.

But the regulations require that the interagency agreement be renewed every three years, and revised if necessary. The interagency agreement "shall include, but not be limited to, a delineation of the process and procedure for" the following:

- Interagency referrals of pupils, which minimize time line delays. This may include written parental consent on the receiving agency's forms.
- Timely exchange of pupil information in accordance with applicable procedures ensuring confidentiality.

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[82] The regulations pled in the original test claim were enacted by the Departments of Mental Health and Education as emergency regulations (Cal. Code Regs., tit. 2, §§ 60000 through 60610, filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)). These regulations were repealed and were superceded by new regulations, effective July 1, 1998. The 1998 regulations are the subject of *Handicapped and Disabled Students II* (02-TC-40, 02-TC-49). Most of the activities required by the original regulations remain the law. However, as indicated in this decision, several activities have been deleted in the 1998 regulations. Since the reimbursement period of this reconsideration begins July 1, 2004, those activities deleted by the 1998 regulations no longer constitute a state-mandated new program or higher level of service for purposes of the original test claim. The analysis of activities that have been modified by the 1998 regulations is provided in the staff analysis for *Handicapped and Disabled Students II* (02-TC-40, 02-TC-49).

[83] The local mental health program is the county community mental health program established in accordance with the Short-Doyle Act (Welf. & Inst. Code, §§ 5600 et seq.) or the county welfare agency when designated pursuant to Government Code section 7572.5. (Cal. Code of Regs., tit. 2, § 60020, subd. (d)).

- Participation of mental health professionals, including those contracted to provide services, at IEP team meetings pursuant to Government Code sections 7572 and 7576.
- Developing or amending the mental health related service goals and objectives, and the frequency and duration of such services indicated on the pupil's IEP.
- Transportation of individuals with exceptional needs to and from the mental health service site when such service is not provided at the school.
- Provision by the school of an assigned, appropriate space for delivery of mental health services or a combination of education and mental health services to be provided at the school.
- Continuation of mental health services during periods of school vacation when required by the IEP.
- Identification of existing public and state-certified nonpublic educational programs, treatment modalities, and location of appropriate residential placements which may be used for placement by the expanded IEP program team.
- Out-of-home placement of seriously emotionally disturbed pupils in accordance with the educational and treatment goals on the IEP.[84]

In addition, section 60100, subdivision (a), of the regulations requires the local mental health program and the special education local plan area liaison person to define the process and procedures for coordinating local services to promote alternatives to out-of-home care of seriously emotionally disturbed pupils.

Accordingly, the Commission finds that Government Code section 7571, and sections 60030 and 60100 of the regulations constitute a state-mandated new program or higher level of service for the following activities:

- Renew the interagency agreement every three years, and revise if necessary.
- Define the process and procedures for coordinating local services to promote alternatives to out-of-home care of seriously emotionally disturbed pupils.

2. <u>Perform an initial assessment of a pupil referred by the local educational agency, and discuss assessment results with the parents and IEP team (Gov. Code, § 7572, Cal. Code Regs., tit. 2, § 60040)</u>

Government Code section 7572, subdivision (a), provides that "a child shall be assessed in all areas related to the suspected handicap by those qualified to make a determination of the child's need for the service before any action is taken with respect to the provision of related services or designated instruction and services to a child, including, but not limited to, services in the area of, … psychotherapy, and other mental health assessments." Government Code section 7572, subdivision (c), states that psychotherapy and other mental health assessments shall be conducted by qualified mental health

[84] California Code of Regulations, title 2, section 60030, subdivision (b).

professionals as specified in regulations developed by the Department of Mental Health and the Department of Education.

Section 60040 of the regulations governs the referral to and the initial assessment by the county. Section 60040, subdivision (a), states that a local education agency may refer a pupil suspected of needing mental health services to the county mental health program when a review of the assessment data documents that the behavioral characteristics of the pupil adversely affect the pupil's educational performance. The pupil's educational performance is measured by standardized achievement tests, teacher observations, work samples, and grade reports reflecting classroom functioning, or other measures determined to be appropriate by the IEP team; the behavioral characteristics of the pupil cannot be defined solely as a behavior disorder or a temporary adjustment problem, or cannot be resolved with short-term counseling; the age of onset was from 30 months to 21 years and has been observed for at least six months; the behavioral characteristics of the pupil are present in several settings, including the school, the community, and the home; and the adverse behavioral characteristics of the pupil are severe, as indicated by their rate of occurrence and intensity.

Section 60040, subdivision (c), states that when a local education agency refers a pupil to the county, the local education agency shall obtain written parental consent to forward educational information to the county and to allow the county mental health professional to observe the pupil during school. The educational information includes a copy of the assessment reports completed in accordance with Education Code section 56327, current and relevant behavior observations of the pupil in a variety of educational and natural settings, and a report prepared by personnel that provided "specialized" counseling and guidance services to the pupil and, when appropriate, an explanation why such counseling and guidance will not meet the needs of the pupil.

Section 60040, subdivision (d), states that "[t]he local mental health program shall be responsible for reviewing the educational information [identified in the paragraph above], observing *if necessary*, the pupil in the school environment, and determining if mental health assessments are needed." (Emphasis added.) Subdivision (d)(1) provides that *"[i]f mental health assessments are deemed necessary by a mental health professional*, a mental health assessment plan shall be developed and the parent's written consent obtained …" (Emphasis added.) This regulation includes language that implies that the observation of the pupil and the preparation of the mental health assessment plan are activities within the discretion of the county. The Commission finds, however, that these activities are mandated by the state when necessary to provide the pupil with a free and appropriate education under federal law. Under the rules of statutory construction, section 60040, subdivision (d), must be interpreted in the context of the entire statutory scheme so that the statutory scheme may be harmonized and have effect.[85] In addition, it is presumed that the administrative agency, like the Departments of Mental Health and Education, did not adopt a regulation that alters the terms of a legislative enactment.[86]

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[85] *Select Base Materials v. Board of Equalization* (1959) 51 Cal.2d 640, 645; *City of Merced v. State of California* (1984) 153 Cal.App.3d 777, 781-782.

[86] *Wallace v. State Personnel Board* (1959) 168 Cal.App.2d 543, 547.

Federal law, through the IDEA, requires the state to *identify*, locate, and evaluate *all* children with disabilities, including children attending private schools, who are in need of special education and related services.[87] The state is also required by federal law to conduct a full and individual initial evaluation to determine whether a child is a child with a qualifying disability and the educational needs of the child.[88] Government Code section 7572, subdivision (a), is consistent with federal law and requires that a child shall be assessed in all areas related to the suspected handicap by those qualified to make a determination of the child's need for the service. In cases where the pupil is suspected of needing mental health services, the state has delegated to the counties the activity of determining the need for service. Accordingly, the Commission finds that the following activities, identified in section 60040, subdivision (d) and (d)(1), are new activities mandated by the state:

- Review the following educational information of a pupil referred to the county by a local education agency for an assessment: a copy of the assessment reports completed in accordance with Education Code section 56327, current and relevant behavior observations of the pupil in a variety of educational and natural settings, a report prepared by personnel that provided "specialized" counseling and guidance services to the pupil and, when appropriate, an explanation why such counseling and guidance will not meet the needs of the pupil.
- If necessary, observe the pupil in the school environment to determine if mental health assessments are needed.
- If mental health assessments are deemed necessary by the county, develop a mental health assessment plan and obtain the parent's written informed consent for the assessment.

The county is then required by section 60040, subdivision (d)(2), to complete the assessment within the time required by Education Code section 56344 (except as expressly provided, the IEP shall be developed within a total time not to exceed 50 days from the date of receipt of the parent's written consent for assessment.) If a mental health assessment cannot be completed within the time limits, the county mental health program shall notify the IEP team administrator or designee no later than 15 days before the scheduled IEP meeting.

Section 60040, subdivision (e), requires the county to provide to the IEP team a written assessment report in accordance with Education Code section 56327. Education Code section 56327 requires that the report include the following information:

- Whether the pupil may need special education and related services.
- The basis for making the determination.
- The relevant behavior noted during the observation of the pupil in the appropriate setting.

[87] 20 United States Code section 1412, subdivision (a)(3).

[88] 20 United States Code section 1414, subdivision (a).

- The relationship of that behavior to the pupil's academic and social functioning.
- The educationally relevant health and development, and medical findings, if any.
- For pupils with learning disabilities, whether there is such a discrepancy between achievement and ability that it cannot be corrected without special education and related services.
- A determination concerning the effects of environmental, cultural, or economic disadvantage, where appropriate.
- The need for specialized services, materials, equipment for pupils with low incidence disabilities.

After the assessment by the county is completed, Government Code section 7572, subdivision (d)(1), requires that the recommendation of the person who conducted the assessment be reviewed and discussed with the parent and the appropriate members of the IEP team before the IEP team meeting. When the proposed recommendation has been discussed with the parent and there is disagreement on the recommendation pertaining to the related service, the parent shall be notified in writing and may require the person from the county who conducted the assessment to attend the IEP team meeting. Government Code section 7572, subdivision (d)(1), states that "the person who conducted the assessment shall attend the individualized education program team meeting if requested."

Government Code section 7572, subdivision (e), requires the local education agency to invite the county to meet with the IEP team to determine the need for the related service and to participate in developing the IEP. The Commission finds, however, that the county's attendance at the IEP meeting at the request of the local education agency is not mandated by the state for the following reasons. Government Code section 7572, subdivision (e), states that *if* the county representative cannot meet with the IEP team, then the representative is required to provide the local education agency written information concerning the need for the service. The Commission finds that the assessment report required by section 60040, subdivision (e), of the regulations satisfies the written information requirement of Government Code section 7572, subdivision (e), and that Government Code section 7572, subdivision (e), does not impose any further requirement on the county to prepare additional written reports. The conclusion that the county is not required by the state to attend the IEP team meeting at the request of the local education agency is further supported by the sentence added to subdivision (e) by Statutes 1985, chapter 1274. That sentence provides the following: "If the responsible public agency representative will not be available to participate in the individualized education program meeting, the local educational agency shall ensure that a qualified substitute is available to explain and interpret the evaluation pursuant to subdivision (d) of Section 56341 of the Education Code.[89] There is no requirement in the law that the qualified substitute has to be a county representative.

[89] Education Code section 56341, subdivision (e), stated the following when the test claim legislation was enacted (as amended by Stats. 1982, ch. 1201): "If a team is developing, reviewing, or revising the individualized education program of an individual

In addition, Government Code section 7572, subdivision (e), imposes a requirement on the county to provide a copy of the written information to the parent or any adult for whom no guardian or conservator has been appointed.

Finally, Government Code section 7572, subdivision (d)(2), provides that if a parent obtains an independent assessment regarding psychotherapy or other mental health services, and the independent assessment is submitted to the IEP team, the county is required to review the independent assessment. The county's recommendation shall be reviewed and discussed with the parent and with the IEP team before the meeting of the IEP team. The county shall attend the IEP team meeting if requested.

Accordingly, the Commission finds that Government Code section 7572 and section 60040 of the regulations constitute a state-mandated new program or higher level of service for the following activities:

- Review the following educational information of a pupil referred to the county by a local education agency for an assessment: a copy of the assessment reports completed in accordance with Education Code section 56327, current and relevant behavior observations of the pupil in a variety of educational and natural settings, a report prepared by personnel that provided "specialized" counseling and guidance services to the pupil and, when appropriate, an explanation why such counseling and guidance will not meet the needs of the pupil.
- If necessary, observe the pupil in the school environment to determine if mental health assessments are needed.
- If mental health assessments are deemed necessary by the county, develop a mental health assessment plan and obtain the parent's written informed consent for the assessment.
- Assess the pupil within the time required by Education Code section 56344.[90]

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with exceptional needs who has been assessed for the purpose of that individualized education program, the district, special education local plan area, or county office, shall ensure that a person is present at the meeting who has conducted an assessment of the pupil or who is knowledgeable about the assessment procedures used to assess the pupil and is familiar with the results of the assessment. The person shall be qualified to interpret the results if the results or recommendations, based on the assessment, are significant to the development of the pupil's individualized education program and subsequent placement."

[90] The existing parameters and guidelines allow reimbursement for mental health assessments and include within that activity the interview with the child and the family, and collateral interviews, as necessary. These activities are not expressly required by the test claim legislation. However, when reconsidering the parameters and guidelines for this program, the Commission has the jurisdiction to consider "a description of the most reasonable methods of complying with the mandate." (Cal. Code Regs., tit. 2, § 1183.1, subd. (a)(1)(A)(4).)

- If a mental health assessment cannot be completed within the time limits, provide notice to the IEP team administrator or designee no later than 15 days before the scheduled IEP meeting.
- Prepare and provide to the IEP team, and the parent or guardian, a written assessment report in accordance with Education Code section 56327. The report shall include the following information: whether the pupil may need special education and related services; the basis for making the determination; the relevant behavior noted during the observation of the pupil in the appropriate setting; the relationship of that behavior to the pupil's academic and social functioning; the educationally relevant health and development, and medical findings, if any; for pupils with learning disabilities, whether there is such a discrepancy between achievement and ability that it cannot be corrected without special education and related services; a determination concerning the effects of environmental, cultural, or economic disadvantage, where appropriate; and the need for specialized services, materials, equipment for pupils with low incidence disabilities.
- Review and discuss the county recommendation with the parent and the appropriate members of the IEP team before the IEP team meeting.
- In cases where the local education agency refers a pupil to the county for an assessment, attend the IEP meeting if requested by the parent.
- Review independent assessments of a pupil obtained by the parent.
- Following review of the independent assessment, discuss the recommendation with the parent and with the IEP team before the meeting of the IEP team.
- In cases where the parent has obtained an independent assessment, attend the IEP team meeting if requested.

3. <u>Participate as a member of the IEP team whenever the assessment of a pupil determines the pupil is seriously emotionally disturbed and residential placement may be necessary (Gov. Code, § 7572.5, subds. (a) and (b); Cal. Code Regs., tit. 2, § 60100)</u>

Government Code section 7572.5, subdivision (a), and section 60100, subdivision (b), of the regulations provide that when an assessment determines that a child is seriously emotionally disturbed as defined in section 300.5 of the Code of Federal Regulations, and any member of the IEP team recommends residential placement based on relevant assessment information, the IEP team shall be expanded to include a representative of the county. Government Code section 7572.5, subdivision (b), requires the expanded IEP team to review the assessment and determine whether (1) the child's needs can reasonably be met through any combination of nonresidential services, preventing the need for out-of-home care; (2) residential care is necessary for the child to benefit from educational services; and (3) residential services are available, which address the needs identified in the assessment and which will ameliorate the conditions leading to the seriously emotionally disturbed designation. Section 60100, subdivision (d), similarly states that the expanded IEP team shall consider all possible alternatives to out-of-home placement.

Section 60100, subdivision (c), states that if the county determines that additional mental health assessments are needed, the county is required to assess or re-assess the pupil in accordance with section 60040.

Section 60100, subdivision (e), states that when residential placement is the final decision of the expanded IEP team, the team shall develop a written statement documenting the pupil's educational and mental health treatment needs that support the recommendation for the placement.

Section 60100, subdivision (f), requires the expanded IEP team to identify one or more appropriate, least restrictive and least costly residential placement alternatives, as specified in the regulation.

Finally, section 60100, subdivision (g), requires the county representative on the expanded IEP team to notify the Local Mental Health Director or designee of the team's decision within one working day of the IEP team meeting. However, effective July 1, 1998, section 60100 of the regulations was amended and this activity is no longer required. Since the reimbursement period for this reconsideration begins July 1, 2004, the Commission finds that the activity of notifying the local mental health director of the decision is not a state-mandated new program or higher level of service.

Accordingly, the Commission finds that Government Code section 7572.5, subdivisions (a) and (b), and section 60100 of the regulations constitute a state-mandated new program or higher level of service for the following activities:

- Participate as a member of the IEP team whenever the assessment of a pupil determines the pupil is seriously emotionally disturbed and residential placement may be necessary.
- Re-assess the pupil in accordance with section 60400 of the regulations, if necessary.

4. Act as the lead case manager, as specified in statute and regulations, if the IEP calls for residential placement of a seriously emotionally disturbed pupil (Gov. Code, §§ 7572.5, subd. (c)(1), 7579; Cal. Code Regs., tit. 2, § 60110)

Government Code section 7572.5, subdivision (c)(1), provides that if the review of the expanded IEP team calls for residential placement of the seriously emotionally disturbed pupil, the county shall act as the lead case manager. That statute further states that "the mental health department shall retain financial responsibility for provision of case management services."

Section 60110, subdivision (a), requires the Local Mental Health Director or the designee to designate a lead case manager to finalize the pupil placement plan with the approval of the parent and the IEP team within 15 days from the decision to place the pupil in a residential facility. Subdivision (c) defines case management duties to include the following activities:

- Convening parents and representatives of public and private agencies in accordance with section 60100, subdivision (f), in order to identify the appropriate residential facility.

- Verifying with the educational administrator or designee the approval of the local governing board of the district, special education service region, or county office pursuant to Education Code section 56342.[91]
- Completing the local mental health program payment authorization in order to initiate out of home care payments.
- Coordinating the completion of the necessary County Welfare Department, local mental health program, and responsible local education agency financial paperwork or contracts.
- Coordinating the completion of the residential placement as soon as possible.
- Developing the plan for and assisting the family and pupil in the pupil's social and emotional transition from home to the residential facility and the subsequent return to the home.
- Facilitating the enrollment of the pupil in the residential facility.
- Conducting quarterly face-to-face contacts with the pupil at the residential facility to monitor the level of care and supervision and the implementation of the treatment services and the IEP.
- Notifying the parent or legal guardian and the local education agency administrator or designee when there is a discrepancy in the level of care, supervision, provision of treatment services, and the requirements of the IEP.
- Coordinating the six-month expanded IEP team meeting with the local education agency administrator or designee.

As of July 1, 1998, however, the activity of verifying with the educational administrator or designee the approval of the local governing board pursuant to Education Code section 56342 is no longer required by section 60100 of the regulations. In addition, the activity of coordinating the six-month expanded IEP team meeting with the local education agency administrator or designee was repealed as of July 1, 1998. Since the

[91] Education Code section 56342 states in relevant part the following:

> Prior to recommending a new placement in a nonpublic, nonsectarian school, the individualized education program team shall submit the proposed recommendation to the local governing board of the district and special education local plan area for review and recommendation regarding the cost of placement.
>
> The local governing board shall complete its review and make its recommendations, if any, at the next regular meeting of the board. A parent or representative shall have the right to appear before the board and submit written and oral evidence regarding the need for nonpublic school placement for his or her child. Any recommendations of the board shall be considered at an individualized education program team meeting, to be held within five days of the board's review.

reimbursement period for this reconsideration begins July 1, 2004, the Commission finds that these two activities are not a state-mandated new program or higher level of service.

Moreover, on April 30, 1986, the Department of Mental Health issued DMH Letter No. 86-12 to all local mental health directors, program chiefs, and administrators, and to county administrative officers regarding the implementation of the test claim legislation. (p. 1513.) On page 1521 of the record, the Department lists the case management duties for seriously emotionally disturbed pupils placed in a residential facility and includes "coordinating the pupil's transportation needs" as a case management duty of the county. This letter issued by the Department of Mental Health was not identified or pled as an executive order in the original test claim, and the activity of "coordinating the pupil's transportation needs" is not expressly required by the test claim statutes or regulations. Moreover, section 60110 was amended on July 1, 1998, to include as a case management activity "coordinating the transportation of the pupil to the facility if needed." Section 60110, as amended on July 1, 1998, is the subject of a pending test claim, *Handicapped and Disabled II* (02-TC-40 and 02-TC-49). Therefore, the Commission finds that "coordinating the pupil's transportation needs" is not mandated by the test claim legislation before the Commission in this reconsideration.

Finally, Government Code section 7579, subdivision (a), requires courts, regional centers for the developmentally disabled, or other non-educational public agencies that engage in referring children to, or placing children in, residential facilities, to notify the administrator of the special education local plan area (SELPA) in which the residential facility is located before the pupil is placed in an out-of-home residential facility. The intent of the legislation, as stated in subdivision (c), is to "encourage communication between the courts and other public agencies that engage in referring children to, or placing children in, residential facilities, and representatives of local educational agencies." Government Code section 7579, subdivision (a), however, does not apply to county mental health departments. The duty imposed by section 7579 to notify the SELPA before the pupil is placed in a residential facility is a duty imposed on a placing agency, like a court or a regional center for the developmentally disabled. This test claim was filed on behalf of county mental health departments.[92] Thus, the Commission finds that Government Code section 7579 does not impose a state-mandated new program or higher level of service on county mental health departments.

Accordingly, the Commission finds that Government Code sections 7572.5, subdivision (c)(1), and section 60110 of the regulations constitute a state-mandated new program or higher level of service for the following activities:

- Designate a lead case manager when the expanded IEP team recommends out-of-home residential placement for a seriously emotionally disturbed pupil. The lead case manager shall perform the following activities:
    1. Convene parents and representatives of public and private agencies in accordance with section 60100, subdivision (f), in order to identify the appropriate residential facility.

[92] Test claim (CSM 4282) filed by County of Santa Clara.

2. Complete the local mental health program payment authorization in order to initiate out of home care payments.
3. Coordinate the completion of the necessary County Welfare Department, local mental health program, and responsible local education agency financial paperwork or contracts.
4. Coordinate the completion of the residential placement as soon as possible.
5. Develop the plan for and assist the family and pupil in the pupil's social and emotional transition from home to the residential facility and the subsequent return to the home.
6. Facilitate the enrollment of the pupil in the residential facility.
7. Conduct quarterly face-to-face contacts with the pupil at the residential facility to monitor the level of care and supervision and the implementation of the treatment services and the IEP.
8. Notify the parent or legal guardian and the local education agency administrator or designee when there is a discrepancy in the level of care, supervision, provision of treatment services, and the requirements of the IEP.

5. <u>Issue payments to providers of out-of-home residential care for the residential and non-educational costs of seriously emotionally disturbed pupils (Gov. Code, § 7581; Cal. Code Regs., tit. 2, § 60200, subd. (e))</u>

Government Code section 7581 requires the county to be financially responsible for the residential and non-educational costs of a seriously emotionally disturbed child placed in an out-of-home residential facility. Section 7581 states the following:

> The residential and noneducational costs of a child placed in a medical or residential facility by a public agency, other than a local education agency, or independently placed in a facility by the parent of the child, shall not be the responsibility of the state or local education agency, but shall be the responsibility of the placing agency or parent [if the parent places the child].

Consistent with Government Code section 7581, section 60200, subdivision (e), of the regulations requires the county welfare department to issue the payments to providers of out-of-home facilities in accordance with Welfare and Institutions Code section 18351, upon receipt of authorization documents from the State Department of Mental Health or a designated county mental health agency. The authorization documents are required to include information sufficient to demonstrate that the child meets all eligibility criteria established in the regulations for this program. (Welf. & Inst. Code, § 18351.) The Department of Social Services is required to determine the rates to be paid to the residential providers in accordance with Welfare and Institutions Code section 18350. (Cal. Code Regs., tit. 2, § 60200, subd. (d).)

Thus, the test claim regulations require that payments to providers of 24-hour out-of-home care be made in accordance with Welfare and Institutions Code sections 18350 and

18351. Welfare and Institutions Code sections 18350 and following govern the payments to 24-hour out-of-home care providers for seriously emotionally disturbed pupils, and were added by the 1985 test claim statute. Welfare and Institutions Code sections 18350 and following were not pled in the original *Handicapped and Disabled Students* test claim. However, since Welfare and Institutions Code sections 18350 and 18351 were identified in the regulations that were pled in the test claim, and sections 18350 and 18351 define the scope of the activity and the costs at issue in this case, the Commission finds that the Commission may properly consider sections 18350 and 18351 on reconsideration of this claim.

Welfare and Institutions Code section 18351, subdivision (a), requires the county welfare department located in the same county as the county mental health agency designated to provide case management services to issue payments to residential care providers upon receipt of authorization documents from the State Department of Mental Health or a designated county mental health agency. Subdivision (a) further states that "[a]uthorization documents shall be submitted directly to the county welfare department clerical unit responsible for issuance of warrants and shall include information sufficient to demonstrate that the child meets all eligibility criteria established in regulations by the State Department of Mental Health, developed in consultation with the State Department of Education."

Welfare and Institutions Code section 18350, subdivision (c), states that "[p]ayments shall be based on rates established in accordance with Sections 11461, 11462, and 11463 and shall be based on providers' actual allowable costs." At the time the test claim legislation was enacted, Welfare and Institutions Code section 11462, subdivision (b), defined "allowable costs" as follows:

> As used in this section, "allowable costs" means: (A) the reasonable cost of, and the cost of providing food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation; (B) reasonable cost of administration and operation necessary to provide the items described in paragraph (A); and (C) reasonable activities performed by social workers employed by group home providers which are not otherwise allowable as daily supervision or as the costs of administration.

Welfare and Institutions Code section 11462 was repealed and replaced in 1989, before the Commission adopted the 1990 Statement of Decision in this case.[93] A similar definition of allowable costs for care and supervision of the pupil in the residential facility remains the law, however, and can now be found in Welfare and Institutions Code section 11460, subdivision (b).[94] Since Government Code section 7581 requires counties to be responsible for the residential and *non-educational* costs of the pupil only, the

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[93] Statutes 1989, chapter 1294.

[94] Welfare and Institutions Code section 11460 was added by Statutes 1989, chapter 1294.

Commission finds that the cost for school supplies are not required to be paid to residential care providers by the counties.

In addition, effective July 1, 1998, the regulations were amended to provide a definition of "care and supervision." The definition does not include issuing payments for the reasonable cost of administration and operation, and the reasonable activities performed by social workers employed by group home providers, which are not otherwise allowable as daily supervision or as the costs of administration.[95] Therefore, since the reimbursement period for this reconsideration begins July 1, 2004, the Commission finds that the activity of issuing payments for the reasonable cost of administration and operation, and the reasonable activities performed by social workers employed by group home providers which are not otherwise allowable as daily supervision or as the costs of administration, do not constitute a state-mandated new program or higher level of service.

Thus, the Commission finds that the requirement to issue payments to providers of 24-hour out-of-home facilities for the costs of food, clothing, shelter, daily supervision, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation, constitutes a state-mandated new program or higher level of service.

Welfare and Institutions Code section 18351, subdivision (b), further requires the county welfare department to submit reports to the State Department of Social Services for reimbursement of payments issued to seriously emotionally disturbed pupils for 24-hour out-of-home care.

Accordingly, the Commission finds that Government Code section 7581 and section 60200, subdivision (e), of the regulations constitute a state-mandated new program or higher level of service for the following activities:

- Issue payments to providers of out-of-home residential care for the residential and non-educational costs of seriously emotionally disturbed pupils. Payments are for the costs of food, clothing, shelter, daily supervision, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation.
- Submit reports to the State Department of Social Services for reimbursement of payments issued to seriously emotionally disturbed pupils for 24-hour out-of-home care.

6. <u>Provide psychotherapy or other mental health services, as defined in regulations, when required by the IEP (Gov. Code, § 7576; Cal. Code Regs., tit. 2, §§ 60020, subd. (a), 60200, subds. (a) and (b))</u>

Government Code section 7576 requires the State Department of Mental Health, or any designated community mental health service (i.e., the county), to provide psychotherapy or other mental health services when required by a pupil' s IEP. Psychotherapy or other mental health services may be provided directly or by contracting with another public

[95] See California Code of Regulations, title 2, section 60025, subdivision (a), (eff. July 1, 1998).

agency, qualified individual, or a state-certified nonpublic, nonsectarian school or agency.

Section 60020, subdivision (a), defines "psychotherapy and other mental health services" as "those services defined in Sections 542 to 543, inclusive, of Title 9 of the California Administrative Code [Department of Mental Health regulations], and provided by a local mental health program directly or by contract." Section 542 of the Department of Mental Health regulations governs the definition of "day services": services that are designed to provide alternatives to 24-hour care and supplement other modes of treatment and residential services. Day services include day care intensive services, day care habilitative services, vocational services and socialization services. These services are defined in section 542 of the regulations as follows:

- Day care intensive services are "services designed and staffed to provide a multidisciplinary treatment program of less than 24 hours per day as an alternative to hospitalization for patients who need active psychiatric treatment for acute mental, emotional, or behavioral disorders and who are expected, after receiving these services, to be referred to a lower level of treatment, or maintain the ability to live independently or in a supervised residential facility."
- Day care habilitative services are "services designed and staffed to provide counseling and rehabilitation to maintain or restore personal independence at the best possible functional level for the patient with chronic psychiatric impairments who may live independently, semi-independently, or in a supervised residential facility which does not provide this service."[96]
- Vocational services are "services designed to encourage and facilitate individual motivation and focus upon realistic and obtainable vocational goals. To the extent possible, the intent is to maximize individual client involvement in skill seeking and skill enhancement, with the ultimate goal of meaningful productive work."

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[96] In comments to the draft staff analysis, the County of Los Angeles asserts that "rehabilitation" should be specifically defined to include the activities identified in section 1810.243 of the regulations adopted by the Department of Mental Health under the Medi-Cal Specialty Mental Health Services Consolidation program. (Cal. Code Regs., tit. 9, § 1810.243.) These activities include "assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources and/or medication education."

The Commission disagrees with the County's request. The plain language of test claim regulations (Cal. Code Regs., tit. 2, §§ 60000 et seq.) does not require or mandate counties to perform the activities defined by section 1810.243 of the Department's title 9 regulations. In addition, the test claim regulations do not reference section 1810.243 of the Department's title 9 regulations for any definition relevant to the program at issue in this case.

- Socialization services are "services designed to provide life-enrichment and social skill development for individuals who would otherwise remain withdrawn and isolated. Activities should be gauged for multiple age groups, be culturally relevant, and focus upon normalization."

Section 543 of the Department of Mental Health regulations defines "outpatient services," which are defined as "services designed to provide short-term or sustained therapeutic intervention for individuals experiencing acute or ongoing psychiatric distress." Outpatient services include the following:

- Collateral services, which are "sessions with significant persons in the life of the patient, necessary to serve the mental health needs of the patient."
- Assessment, which is defined as "services designed to provide formal documented evaluation or analysis of the cause or nature of the patient's mental, emotional, or behavioral disorder. Assessment services are limited to an intake examination, mental health evaluation, physical examination, and laboratory testing necessary for the evaluation and treatment of the patient's mental health needs."
- Individual therapy, which is defined as "services designed to provide a goal directed therapeutic intervention with the patient which focuses on the mental health needs of the patient."
- Group therapy, which are "services designed to provide a goal directed, face-to-face therapeutic intervention with the patient and one or more other patients who are treated at the same time, and which focuses on the mental health needs of the patient."
- Medication, which is defined to include "the prescribing, administration, or dispensing of medications necessary to maintain individual psychiatric stability during the treatment process. This service shall include the evaluation of side effects and results of medication."
- Crisis intervention, which means "immediate therapeutic response which must include a face-to-face contact with a patient exhibiting acute psychiatric symptoms to alleviate problems which, if untreated, present an imminent threat to the patient or others."

The County of Los Angeles, in comments to the draft staff analysis, argues that all of the activities listed above should be identified as reimbursable state-mandated activities. However, as of July 1, 1998, the activities of providing vocational services, socialization services, and crisis intervention to pupils are no longer required by section 60020 of the regulations. The final statement of reasons for the 1998 adoption of section 60020 of the regulations by the Departments of Mental Health and Education provides the following reason for the deletion of these activities:

> The provision of vocational services is assigned to the State Department of Rehabilitation by Government Code section 7577.
>
> Crisis service provision is delegated to be "from other public programs or private providers, as appropriate" by these proposed regulations in

> Section 60040(e) because crisis services are a medical as opposed to educational service. They are, therefore, excluded under both the Tatro and Clovis decisions. These precedents apply because "medical" specialists must deliver the services. A mental health crisis team involves specialized professionals. Because of the cost of these professional services, providing these services would be a financial burden that neither the schools nor the local mental health services are intended to address in this program.
>
> The hospital costs of crisis service provision are explicitly excluded from this program in the Clovis decision for the same reasons.
>
> Additionally, the IEP process is one that responds slowly due to the problems inherent in convening the team. It is, therefore, a poor avenue for the provision of crisis services. While the need for crisis services can be a predictable requirement over time, the particular medical requirements of the service are better delivered through the usual local mechanisms established specifically for this purpose.[97]

Since the reimbursement period for this reconsideration begins July 1, 2004, the Commission finds that the activities of providing vocational services, socialization services, and crisis intervention to pupils do not constitute a state-mandated new program or higher level of service.

In addition, the County of Los Angeles specifically requests reimbursement for "medication monitoring." The phrase "medication monitoring" was not included in the original test claim legislation. "Medication monitoring" was added to the regulations for this program in 1998 (Cal. Code Regs. tit. 2, § 60020.) "Medication monitoring" is part of the new, and current, definition of "mental health services" that was adopted by the Departments of Mental Health and Education in 1998. The current definition of "mental health services" and "medication monitoring" is the subject of the pending test claim, *Handicapped and Disabled Students II* (02-TC-40 and 02-TC-49), and will not be specifically analyzed here. But, as of 1998, "dispensing of medications necessary to maintain individual psychiatric stability during the treatment process" was deleted from the definition of "mental health services." Since the reimbursement period for this reconsideration begins July 1, 2004, the Commission finds that the activity of "dispensing of medications necessary to maintain individual psychiatric stability during the treatment process" does not constitute a state-mandated new program or higher level of service.

Finally, section 60200, subdivisions (a) and (b), of the regulations clarifies that counties are financially responsible for providing the mental health services identified in the IEP of a seriously emotionally disturbed pupil placed in an out-of-home residential facility located within the State of California. Mental health services provided to a seriously emotionally disturbed pupil shall be provided either directly or by contract.

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[97] Final Statement of Reasons, pages 55-56.

Accordingly, the Commission finds that Government Code section 7576, and sections 60020 and 60200 of the regulations constitute a state-mandated new program or higher level of service for the following activity:

- Providing psychotherapy or other mental health services identified in a pupil's IEP, as defined in sections 542 and 543 of the Department of Mental Health regulations. However, the activities of providing vocational services, socialization services, and crisis intervention to pupils, and dispensing medications necessary to maintain individual psychiatric stability during the treatment process, do *not* constitute a state-mandated new program or higher level of service.

7. <u>Participate in due process hearings relating to issues involving mental health assessments or services (Gov. Code, § 7586; Cal. Code Regs., tit. 2, § 60550)</u>

Government Code section 7586, subdivision (a), addresses the due process procedures when disputes regarding special education and related services arise. That section requires all state departments and their designated local agencies to be governed by the procedural safeguards required by federal law. The designated local agency is the county mental health program established in accordance with the Short-Doyle Act.[98]

Government Code section 7586, subdivision (a), states the following:

> All state departments, and their designated local agencies, shall be governed by the procedural safeguards required in Section 1415 of Title 20 of the United States Code. A due process hearing arising over a related service or designated instruction and service shall be filed with the Superintendent of Public Instruction. Resolution of all issues shall be through the due process hearing process established in Chapter 5 (commencing with Section 56500) of Part 30 of Division 4 of the Education Code. The decision issued in the due process hearing shall be binding on the department having responsibility for the services in issue as prescribed by this chapter.[99]

The due process hearing procedures identified in Education Code section 56501 allow the parent and the public education agency to initiate the due process hearing procedures when there is a proposal to initiate or change the identification, assessment, or educational placement of the child or the provision of a free, appropriate public education to the child; there is a refusal to initiate or change the identification, assessment, or educational placement of the child or the provision of a free, appropriate public education to the child; or when the parent refuses to consent to an assessment of the child. The due

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[98] Government Code section 7571; California Code of Regulations, title 2, section 60020, subdivision (d).

[99] Section 60550 of the regulations contains similar language and provides that "[d]ue process hearing procedures apply to the resolution of disagreements between parents and a public agency regarding the proposal or refusal of a public agency to initiate or change the identification, assessment, educational placement, or the provision of special education and related services to the pupil."

process hearing rights include the right to a mediation conference pursuant to Education Code section 56500.3 at any point during the hearing process; the right to examine pupil records; and the right to a fair and impartial administrative hearing at the state level, before a person knowledgeable in the laws governing special education and administrative hearings, under contract with the department, pursuant to Education Code section 56505.

Education Code section 56505, subdivision (e), further affords the parties the right to be accompanied and advised by counsel and by individuals with special knowledge or training relating to the problems of children and youth with disabilities; the right to present evidence, written arguments, and oral arguments; the right to confront, cross-examine, and compel the attendance of witnesses; the right to written findings of fact and decision; the right to be informed by the other parties to the hearing of the issues in dispute; and the right to receive a copy of all documents and a list of witnesses from the opposing party.

The Commission finds that the county's participation in the due process hearings relating to issues involving mental health assessments or services constitutes a state-mandated new program or higher level of service. Although federal law mandates the due process hearing procedures (20 U.S.C. § 1415), it is state law, rather than federal law, that requires counties to participate in due process hearings involving mental health assessment or service issues.

This finding is consistent with the Supreme Court's decision in the recent case of *San Diego Unified School District v. Commission on State Mandates*.[100] In the *San Diego Unified School District* case, the Supreme Court held that all due process hearing costs with respect to a mandatory expulsion of a student (those designed to satisfy the minimum requirements of federal due process, and those due process requirements enacted by the state that may have exceeded federal law) were reimbursable pursuant to article XIII B, section 6 since it was state law that required school districts to incur the hearing costs.[101]

Accordingly, the Commission finds that Government Code section 7586 and section 60550 of the regulations constitute a state-mandated new program or higher level of service for the following activity:

- Participation in due process hearings relating to issues involving mental health assessments or services.

III. Does the test claim legislation impose costs mandated by the state within the meaning of article XIII B, section 6 and Government Code section 17514?

In order for the activities listed above to impose a reimbursable, state-mandated program under article XIII B, section 6 of the California Constitution, two additional elements must be satisfied. First, the activities must impose costs mandated by the state pursuant

[100] *San Diego Unified School District, supra*, 33 Cal.4th 859.

[101] *Id.* at pages 881-882.

to Government Code section 17514.[102] Second, the statutory exceptions to reimbursement listed in Government Code section 17556 cannot apply.

Government Code section 17514 defines "costs mandated by the state" as any increased cost a local agency or school district is required to incur as a result of a statute that mandates a new program or higher level of service.

Government Code section 17556 states that the Commission shall not find costs mandated by the state, as defined in section 17514, in any claim submitted by a local agency or school district, if, after a hearing, the commission finds that:

> (a) The claim is submitted by a local agency or school district that requested legislative authority for that local agency or school district to implement the program specified in the statute, and that statute imposes costs upon that local agency or school district requesting the legislative authority. A resolution from the governing body or a letter from a delegated representative of the governing body of a local agency or school district that requests authorization for that local agency or school district to implement a given program shall constitute a request within the meaning of this paragraph.
>
> (b) The statute or executive order affirmed for the state a mandate that had been declared existing law or regulation by action of the courts.
>
> (c) The statute or executive order imposes a requirement that is mandated by a federal law or regulation and results in costs mandated by the federal government, unless the statute or executive order mandates costs that exceed the mandate in that federal law or regulation. This subdivision applies regardless of whether the federal law or regulation was enacted or adopted prior to or after the date on which the state statute or executive order was enacted or issued.
>
> (d) The local agency or school district has the authority to levy service charges, fees, or assessments sufficient to pay for the mandated program or increased level of service.
>
> (e) The statute, executive order, or an appropriation in a Budget Act or other bill provides for offsetting savings to local agencies or school districts that result in no net costs to the local agencies or school districts, or includes additional revenue that was specifically intended to fund the costs of the state mandate in an amount sufficient to fund the cost of the state mandate.
>
> (f) The statute or executive order imposed duties that were expressly included in a ballot measure approved by the voters in a statewide or local election.
>
> (g) The statute created a new crime or infraction, eliminated a crime or infraction, or changed the penalty for a crime or infraction, but only for

[102] See also, *Lucia Mar Unified School Dist.*, *supra*, 44 Cal.3d 830, 835

> that portion of the statute relating directly to the enforcement of the crime or infraction.

Except for Government Code section 17556, subdivision (e), the Commission finds that the exceptions listed in section 17556 are not relevant to this claim, and do not apply here. Since the Legislature has appropriated funds for this program in the 2004 Budget Bill, however, Government Code section 17556, subdivision (e), is relevant and is analyzed below.

A. Government Code section 17556, subdivision (e), does not apply to deny this claim

Government Code section 17556, subdivision (e), states the Commission shall not find costs mandated by the state if the Commission finds that:

> The statute, executive order, or an appropriation in a Budget Act or other bill provides for offsetting savings to local agencies or school districts that result in no net costs to the local agencies or school districts, *or includes additional revenue that was specifically intended to fund the costs of the state mandate in an amount sufficient to fund the cost of the state mandate*. (Emphasis added.)

The Budget Acts of 2003 and 2004 contain appropriations " considered offsetting revenues within the meaning of Government Code section 17556, subdivision (e)." The Budget Act of 2003 appropriated $69 million from the federal special education fund to counties to be used exclusively to support mental health services identified in a pupil's IEP and provided during the 2003-04 fiscal year by county mental health agencies pursuant to the test claim legislation. (Stats. 2003, ch. 157, item 6110-161-0890, provision 17.) The bill further states in relevant part that the funding shall be considered offsetting revenue pursuant to Government Code section 17556, subdivision (e):

> This funding shall be considered offsetting revenues within the meaning of subdivision (e) of section 17556 of the Government Code for any reimbursable mandated cost claim for provision of these mental health services provided in 2003-04.

The Budget Act of 2004 similarly appropriated $69 million to counties from the federal special education fund to be used exclusively to support mental health services provided during the 2004-05 fiscal year pursuant to the test claim legislation. (Stats. 2004, ch. 208, item 6110-161-0890, provision 10.) The appropriation was made as follows:

> Pursuant to legislation enacted in the 2003-04 Regular Session, of the funds appropriated in Schedule (4) of this item, $69,000,000 shall be used exclusively to support mental health services provided during the 2004-05 fiscal year by county mental health agencies pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of the Government Code and that are included within an individualized education program pursuant to the Federal Individuals with Disabilities Education Act (IDEA).

The Budget Act of 2004 does not expressly identify the $69 million as "offsetting revenues within the meaning of Government Code section 17556, subdivision (e)." But

the statute does contain language that the appropriation was made "Pursuant to legislation enacted in the 2003-04 Regular Session." As indicated above, it is the 2003-04 Budget Bill that contains the language regarding the Legislature's intent that the $69 million is considered offsetting revenue within the meaning of Government Code section 17556, subdivision (e).

In order for Government Code section 17556, subdivision (e), to apply to deny this claim for fiscal year 2004-05, the plain language of the statute requires that two elements be satisfied. First, the statute must include additional revenue that was specifically intended to fund the costs of the state mandate. Second, the appropriation must be in an amount sufficient to fund the cost of the state mandate.

The Commission finds that the Legislature intended to fund the costs of this state-mandated program for fiscal year 2004-05 based on the language used by the Legislature that the funds "shall be considered offsetting revenues within the meaning of Government Code section 17556, subdivision (e)." Under the rules of statutory construction, it is presumed that the Legislature is aware of existing laws and that it enacts new laws in light of the existing law.[103] In this case, the Legislature specifically referred to Government Code section 17556, subdivision (e), when appropriating the $69 million. Thus, it must be presumed that the Legislature was aware of the plain language of Government Code section 17556, subdivision (e), and that its application results in a denial of a test claim.

But, based on public records, the second element under Government Code section 17556, subdivision (e), requiring that the appropriation must be *in an amount sufficient* to fund the cost of the state mandate, has not been satisfied. According to the State Controller's Deficiency Report issued on May 2, 2005, the amounts appropriated for this program in fiscal years 2003-04 and 2004-05 are not sufficient to pay the claims received by the State Controller's Office. Unpaid claims for fiscal year 2003-04 total $66,915,606. The unpaid claims for fiscal year 2004-05 total $68,958,263.[104]

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[103] *Williams v. Superior Court* (2001) 92 Cal.App.4th 612, 624.

[104] The State Controller's Deficiency Report is prepared pursuant to Government Code section 17567. Government Code section 17567 requires that in the event the amount appropriated for reimbursement of a state-mandated program is not sufficient to pay all of the claims approved by the Controller, the Controller shall prorate claims in proportion to the dollar amount of approved claims timely filed and on hand at the time of proration. The Controller shall then issue a report of the action to the Department of Finance, the Chairperson of the Joint Legislative Budget Committee, and the Chairperson of the respective committee in each house of the Legislature that considers appropriations. The Deficiency Report is, thus, an official record of a state agency and is properly subject to judicial notice by the court. (*Munoz v. State* (1995) 33 Cal.App.4th 1767, 1773, fn. 2; *Chas L. Harney, Inc. v. State of California* (1963) 217 Cal.App.2d 77, 85-87.)

The Deficiency Report lists the total unpaid claims for this program as follows:

1999 and prior Local Government Claims Bills	$ 8,646
2001-02	124,940,258

This finding is further supported by the 2004 report published by Stanford Law School, which indicates that "$69 million represented only approximately half of the total funding necessary to maintain AB 3632 services."[105]

Accordingly, the Commission finds that Government Code section 17556, subdivision (e), does not apply to deny this claim for fiscal year 2004-05. Eligible claimants are, however, required to identify the funds received from the $69 million appropriation as an offset to be deducted from the costs claimed.[106]

Based on the program costs identified by the State Controller's Office, the Commission further finds that counties do incur increased costs mandated by the state pursuant to Government Code section 17514 for this program. However, as more fully discussed below, the state has established cost-sharing mechanisms for some of the mandated activities that affect the total costs incurred by a county.

B. Increased costs mandated by the state for providing psychotherapy or other mental health treatment services, and for the residential and non-educational costs of a pupil placed in an out-of-home residential facility

In the Commission's 1990 Statement of Decision, the Commission concluded that the costs incurred for providing psychotherapy or other mental health treatment services were subject to the Short-Doyle Act. Under the Short-Doyle Act, the state paid 90 percent of the total costs of mental health treatment services and the counties paid the remaining 10 percent. Thus, the Commission concluded that counties incurred increased costs mandated by the state in an amount that equaled 10 percent of the total psychotherapy or other mental health treatment costs. The Commission further concluded that conducting assessments, participation on an expanded IEP team, and case management services for seriously emotionally disturbed pupils placed in residential facilities were not subject to the Short-Doyle Act and, thus, were 100 percent reimbursable. The Statement of Decision contains no findings regarding the activity of issuing and paying providers of out-of-home residential care for the residential and non-educational costs of seriously emotionally disturbed pupils.

Since the Statement of Decision was issued, the law with respect to the funding of psychotherapy or other mental health treatment services has changed. In addition, the Commission finds that the original Statement of Decision does not reflect the cost sharing ratio established by the Legislature in Welfare and Institutions Code section 18355 with respect to the residential care of seriously emotionally disturbed pupils. These issues are addressed below.

2002-03	124,871,698
2003-04	66,915,606
2004-05	68,958,263

[105] "Challenge and Opportunity – An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California," Youth and Education Law Clinic, Stanford Law School, May 2004, page 20.

[106] Government Code section 17514; California Code of Regulations, title 2, section 1183.1.

1. <u>The costs for providing psychotherapy or other mental health treatment services</u>

The test claim legislation (Stats. 1985, ch. 1274) amended Welfare and Institutions Code section 5651 to require that the annual Short-Doyle plan for each county include a description of the services required by Government Code sections 7571 and 7576 (psychotherapy or other mental health treatment services), including the cost of the services. Section 60200 of the regulations required the county to be financially responsible for the provision of mental health treatment services and that reimbursement to the provider of the services shall be based on a negotiated net amount or rate approved by the Director of Mental Health as provided in Welfare and Institutions Code section 5705.2, or the provider's reasonable actual cost. Welfare and Institutions Code section 5705.2 imposed a cost-sharing ratio for mental health treatment services between the state and the counties, with the state paying 90 percent and the counties paying 10 percent of the total costs.

In 1993, the Sixth District Court of Appeal in the *County of Santa Clara* case upheld the Commission's finding that psychotherapy or other mental health treatment services were to be funded as part of the Short-Doyle Act and, thus, only 10 percent of the total costs for treatment were reimbursable under article XIII B, section 6. The court interpreted the test claim legislation as follows:

> County entered into an NNA [negotiated net amount] contract with the state in lieu of the Short-Doyle plan and budget. (Welf. & Inst. Code, § 5705.2.) The NNA contract covers mental health services in the contracting county. The amount of money the state provides is the same whether the county signs a NNA contract or adopts a Short-Doyle plan…. By adding subdivision (g) to Welfare and Institutions Code section 5651, the legislature designated that the mental health services provided pursuant to Government Code section 7570 et seq. were to be funded as part of the Short-Doyle program. County's NNA contract was consistent with this intent. Accordingly, the fact that County entered into an NNA contract rather than a Short-Doyle plan and budget is not relevant.

Based on these findings, the court concluded that only 10 percent of the costs were "costs mandated by the state" and, thus, reimbursable under article XIII B, section 6. The court held as follows:

> By placing these services within Short-Doyle, however, the legislature limited the extent of its mandate for these services to the funds provided through the Short-Doyle program. A Short-Doyle agreement or NNA contract sets the maximum obligation incurred by a county for providing the services listed in the agreement or contract. "Counties may <u>elect</u> to appropriate more than their 10 per cent share, but in no event can they be <u>required</u> to do so." (*County of Sacramento v. Loeb* (1984) 160 Cal.App.3d 446, 450.) Since the services were subject to the Short-Doyle formula under which the state provided 90 per cent of the funds and the county 10 per cent, that 10 per cent was reimbursable under

> section 6, article XIII B of the California Constitution. (Emphasis in original.)

There have been "intervening changes in the law" with respect to the costs for psychotherapy or other mental health treatment services, however. Thus, the decision in the *County of Santa Clara* case with respect to the inclusion of mental health treatment services for special education pupils in the Short-Doyle plan no longer applies and is not binding on the Commission for purposes of this reconsideration.[107]

In 1991, the Legislature enacted realignment legislation that repealed the Short-Doyle Act and replaced the sections with the Bronzan-McCorquodale Act. (Stats. 1991, ch. 89, §§ 63 and 173.) The realignment legislation became effective on June 30, 1991. The parties have disputed whether the Bronzan-McCorquodale Act keeps the cost-sharing ratio, with the state paying 90 percent and the counties paying 10 percent, for the cost of psychotherapy or other mental health treatment services for special education pupils.

The Commission finds, however, that the dispute does not need to be resolved for purposes of this reconsideration. Section 38 of Statutes 2002, chapter 1167 (Assem. Bill 2781) prohibits the funding provisions of the Bronzan-McCorquodale Act from affecting the responsibility of the state to fund psychotherapy and other mental health treatment services for handicapped and disabled pupils and requires the state to provide reimbursement to counties for those services for all allowable costs incurred. Section 38 also states the following:

> *For reimbursement claims for services delivered in the 2001-02 fiscal year and thereafter*, counties are *not* required to provide any share of those costs or to fund the cost of any part of these services with money received from the Local Revenue Fund [i.e. realignment funds]. (Emphasis added.)

In addition, SB 1895 (Stats. 2004, ch. 493, § 6) provides that realignment funds used by counties for this program "are eligible for reimbursement from the state *for all allowable costs* to fund assessments, psychotherapy, and other mental health services . . . ," and that the finding by the Legislature is "declaratory of existing law." (Emphasis added.)

Therefore, beginning July 1, 2001, the 90 percent-10 percent cost-sharing ratio for the costs incurred for psychotherapy and other mental health treatment services no longer applies. Since the period of reimbursement for purposes of this reconsideration begins July 1, 2004, and section 38 of Statutes 2002,chapter 1167 is still in effect, all of the county costs for psychotherapy or other mental health treatment services are reimbursable, less any applicable offsets that are identified below.

2. The residential and non-educational costs of a seriously emotionally disturbed child placed in an out-of-home residential facility

Government Code section 7581 requires the county to be financially responsible for the residential and non-educational costs of a seriously emotionally disturbed child placed in an out-of-home residential facility. As described above, the residential and non-

[107] *George Arakelian Farms, Inc., supra,* 49 Cal.3d 1279, 1291.

educational costs include the costs for food, clothing, shelter, daily supervision, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation.

Welfare and Institutions Code section 18355 describes a cost-sharing formula for the payment of these costs. That section states in relevant part the following:

> Notwithstanding any other provision of law, 24-hour out-of-home care for seriously emotionally disturbed children who are placed in accordance with Section 7572.5 of the Government Code shall be funded from a separate appropriation in the budget of the State Department of Social Services in order to fund both 24-hour out-of-home care payment and local administrative costs. Reimbursement for 24-hour out-of-home payment costs shall be from that appropriation, *subject to the same sharing ratio as prescribed in subdivision (c) of Section 15200*, and available funds… (Emphasis added.)

Since 1991, Welfare and Institutions Code section 15200, subdivision (c)(1), has provided that for counties that meet the performance standards or outcome measures in Welfare and Institutions Code section 11215, the state shall appropriate 40 percent of the sum necessary for the adequate care of each child. Thus, for those counties meeting the performance measures, their increased cost mandated by the state would equal 60 percent of the total cost of care for each special education child placed in an out-of-home residential facility, less any applicable offset.

When a county does not meet the performance standards or outcome measures in Welfare and Institutions Code section 11215, state funding for the program decreases and the counties are liable for the decreased cost.[108] The Commission finds that a county's cost incurred for the decrease in the state's share of the costs as a result of the county's failure to meet the performance standards, are not costs mandated by the state and are not reimbursable. Counties are mandated by the state to meet the performance standards for residential facilities.[109]

Therefore, the Commission finds that counties incur increased costs mandated by the state in an amount that equals 60 percent of the total residential and non-educational costs of a seriously emotionally disturbed child placed in an out-of-home residential facility.

C. Identification of offsets

Reimbursement under article XIII B, section 6 and Government Code section 17514 is required only for the increased costs mandated by the state. As determined by the California Supreme Court, the intent behind section 6 was to prevent the state from

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[108] Welfare and Institutions Code sections 15200, subdivision (c)(2), and 11215, subdivision (b)(5).

[109] *Ibid.*

forcing new programs on local governments that require an increased expenditure by local government of their limited tax revenues.[110]

The 1990 Statement of Decision does not identify any offsetting revenues. The parameters and guidelines for this program lists the following reimbursements that must be deducted from the costs claimed:

- Any direct payments (categorical funding) received from the State which are specifically allocated to this program; and
- Any other reimbursements for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g. federal, state, etc.

The Commission agrees with the identification of any direct payments or categorical funds appropriated by the Legislature specifically for this program as an offset to be deducted from the costs claimed. In the past, categorical funding has been provided by the state for this program in the amount of $12.3 million.[111] The categorical funding was eliminated, however, in the Budget Acts of 2002 through 2004.

If, however, funds are appropriated in the Budget Act for this program, such as the $69 million appropriation in the 2004-05 Budget Act, such funds are required to be identified as an offset.

The Commission disagrees with the language in the existing parameters and guidelines that excludes private insurance payments as offsetting revenue. Federal law authorizes public agencies to access private insurance proceeds for services provided under the IDEA if the parent consents.[112] Thus, to the extent counties obtain private insurance proceeds with the consent of a parent for purposes of this program, such proceeds must be identified as an offset and deducted from the costs claimed. This finding is consistent with the California Supreme Court's decision in *County of Fresno v. State of California*. In the *County of Fresno* case, the court clarified that article XIII B, section 6 requires reimbursement by the state only for those expenses that are recoverable from tax revenues. Reimbursable costs under article XIII B, section 6, do not include reimbursement received from other non-tax sources.[113]

The Commission further disagrees with the language in the existing parameters and guidelines that excludes Medi-Cal payments as offsetting revenue. Federal law authorizes public agencies, with certain limitations, to use public insurance benefits, such as Medi-Cal, to provide or pay for services required under the IDEA.[114] Federal law limits this authority as follows:

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[110] *County of Fresno v. State of California* (1991) 53 Cal.3d 482, 487; *County of San Diego, supra*, 15 Cal.4th at page 81.

[111] Budget Acts of 1994-2001, Item 4440-131-0001.

[112] 34 Code of Federal Regulations section 300.142, subdivision (f).

[113] *County of Fresno, supra,* 53 Cal.3d at page 487.

[114] 34 Code of Federal Regulations section 300.142, subdivision (e).

> (2) With regard to services required to provide FAPE [free appropriate public education] to an eligible child under this part, the public agency-
>
> (i) May not require parents to sign up for or enroll in public insurance programs in order for their child to receive FAPE under Part B of the Act;
>
> (ii) May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but pursuant to paragraph (g)(2) of this section, may pay the cost that the parent would be required to pay;
>
> (iii) May not use a child's benefits under a public insurance program if that use would
>
> (A) Decrease available lifetime coverage or any other insured benefit;
>
> (B) Result in the family paying for services that would otherwise be covered by the public insurance program and that are required for the child outside of the time the child is in school;
>
> (C) Increase premiums or lead to the discrimination of insurance; or
>
> (D) Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.[115]

According to the 2004 report published by Stanford Law School, 51.8 percent of the students receiving services under the test claim legislation are Medi-Cal eligible.[116] Thus, the Commission finds to the extent counties obtain proceeds under the Medi-Cal program from either the state or federal government for purposes of this mandated program, such proceeds must be identified as an offset and deducted from the costs claimed.

In addition, Government Code section 7576.5 describes offsetting revenue to counties transferred from local educational agencies for this program as follows:

> If funds are appropriated to local educational agencies to support the costs of providing services pursuant to this chapter, the local educational agencies shall transfer those funds to the community mental health services that provide services pursuant to this chapter in order to reduce

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[115] 34 Code of Federal Regulations section 300.142, subdivision (e)(2)

[116] "Challenge and Opportunity – An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California," Youth and Education Law Clinic, Stanford Law School, May 2004, page 20.

> the local costs of providing these services. These funds shall be used exclusively for programs operated under this chapter and are offsetting revenues in any reimbursable mandate claim relating to special education programs and services.

Government Code section 7576.5 was added by the Legislature in 2003 (Stats. 2003, ch. 227) and became operative and effective on August 11, 2003. Thus, the Commission finds money received by counties pursuant to Government Code section 7576.5 shall be identified as an offset and deducted from the costs claimed.

Finally, the existing parameters and guidelines do not require eligible claimants to offset any Short-Doyle funding, and specifically excludes such funding as an offset. As indicated above, the Short-Doyle Act was repealed and replaced with the realignment legislation of the Bronzan-McCorquodale Act. Based on the plain language of SB 1895 (Stats. 2004, ch. 493, § 6), realignment funds used by a county for this mandated program are not required to be deducted from the costs claimed. Section 6 of SB 1895 adds, as part of the Bronzan-McCorquodale Act, section 5701.6 to the Welfare and Institutions Code. Section 5701.6 states in relevant part the following:

> Counties may utilize money received from the Local Revenue Fund [realignment] …to fund the costs of any part of those services provided pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code. *If money from the Local Revenue Fund is used by counties for those services, counties are eligible for reimbursement from the state for all allowable costs* to fund assessments, psychotherapy, and other mental health services allowable pursuant to Section 300.24 of Title 34 of the Code of Federal Regulations [IDEA] and required by Chapter 26.5 … of the Government Code. (Emphasis added.)

Thus, the Commission finds that realignment funds used by a county for this mandated program are not required to be identified as an offset and deducted from the costs claimed.

Accordingly, the Commission finds that the following revenue and/or proceeds must be identified as offsets and be deducted from the costs claimed:

- Funds received by a county pursuant to Government Code section 7576.5.
- Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes funds received by a county pursuant to the $69 million appropriation to counties for purposes of this mandated program in the Budget Act of 2004 ((Stats. 2004, ch. 208, item 6110-161-0890,
provision 10).
- Private insurance proceeds obtained with the consent of a parent for purposes of this program.

- Medi-Cal proceeds obtained from the state or federal government that pay a portion of the county services provided to a pupil under this mandated program in accordance with federal law.
- Any other reimbursement received from the federal or state government, or other non-local source.[117]

CONCLUSION

The Commission concludes that the test claim legislation imposes a reimbursable state-mandated program on counties pursuant to article XIII B, section 6 of the California Constitution and Government Code section 17514 for the *increased costs* in performing the following activities:

1. Renew the interagency agreement with the local educational agency every three years and, if necessary, revise the agreement (Gov. Code, § 7571; Cal. Code Regs., tit. 2, §§ 60030, 60100)
   - Renew the interagency agreement every three years, and revise if necessary.
   - Define the process and procedures for coordinating local services to promote alternatives to out-of-home care of seriously emotionally disturbed pupils.
2. Perform an initial assessment of a pupil referred by the local educational agency, and discuss assessment results with the parents and IEP team (Gov. Code, § 7572, Cal. Code Regs., tit. 2, § 60040)
   - Review the following educational information of a pupil referred to the county by a local educational agency for an assessment: a copy of the assessment reports completed in accordance with Education Code section 56327, current and relevant behavior observations of the pupil in a variety of educational and natural settings, a report prepared by personnel that provided "specialized" counseling and guidance services to the pupil and, when appropriate, an explanation why such counseling and guidance will not meet the needs of the pupil.
   - If necessary, observe the pupil in the school environment to determine if mental health assessments are needed.
   - If mental health assessments are deemed necessary by the county, develop a mental health assessment plan and obtain the parent's written informed consent for the assessment.
   - Assess the pupil within the time required by Education Code section 56344.
   - If a mental health assessment cannot be completed within the time limits, provide notice to the IEP team administrator or designee no later than 15 days before the scheduled IEP meeting.
   - Prepare and provide to the IEP team, and the parent or guardian, a written assessment report in accordance with Education Code section 56327. The report

[117] *County of Fresno, supra,* 53 Cal.3d at page 487; California Code of Regulations, title 2, section 1183.1, subdivision (a)(8).

shall include the following information: whether the pupil may need special education and related services; the basis for making the determination; the relevant behavior noted during the observation of the pupil in the appropriate setting; the relationship of that behavior to the pupil's academic and social functioning; the educationally relevant health and development, and medical findings, if any; for pupils with learning disabilities, whether there is such a discrepancy between achievement and ability that it cannot be corrected without special education and related services; a determination concerning the effects of environmental, cultural, or economic disadvantage, where appropriate; and the need for specialized services, materials, equipment for pupils with low incidence disabilities.

- Review and discuss the county recommendation with the parent and the appropriate members of the IEP team before the IEP team meeting.
- In cases where the local education agency refers a pupil to the county for an assessment, attend the IEP meeting if requested by the parent.
- Review independent assessments of a pupil obtained by the parent.
- Following review of the independent assessment, discuss the recommendation with the parent and with the IEP team before the meeting of the IEP team.
- In cases where the parent has obtained an independent assessment, attend the IEP team meeting if requested.

3. Participate as a member of the IEP team whenever the assessment of a pupil determines the pupil is seriously emotionally disturbed and residential placement may be necessary (Gov. Code, § 7572.5, subds. (a) and (b); Cal. Code Regs., tit. 2, § 60100)
   - Participate as a member of the IEP team whenever the assessment of a pupil determines the pupil is seriously emotionally disturbed and residential placement may be necessary.
   - Re-assess the pupil in accordance with section 60400 of the regulations, if necessary.
4. Act as the lead case manager if the IEP calls for residential placement of a seriously emotionally disturbed pupil (Gov. Code, § 7572.5, subd. (c)(1); Cal. Code Regs., tit. 2, § 60110)
   - Designate a lead case manager when the expanded IEP team recommends out-of-home residential placement for a seriously emotionally disturbed pupil. The lead case manager shall perform the following activities:
     1. Convene parents and representatives of public and private agencies in accordance with section 60100, subdivision (f), in order to identify the appropriate residential facility.
     2. Complete the local mental health program payment authorization in order to initiate out of home care payments.

3. Coordinate the completion of the necessary County Welfare Department, local mental health program, and responsible local education agency financial paperwork or contracts.
4. Coordinate the completion of the residential placement as soon as possible.
5. Develop the plan for and assist the family and pupil in the pupil's social and emotional transition from home to the residential facility and the subsequent return to the home.
6. Facilitate the enrollment of the pupil in the residential facility.
7. Conduct quarterly face-to-face contacts with the pupil at the residential facility to monitor the level of care and supervision and the implementation of the treatment services and the IEP.
8. Notify the parent or legal guardian and the local education agency administrator or designee when there is a discrepancy in the level of care, supervision, provision of treatment services, and the requirements of the IEP.

5. Issue payments to providers of out-of-home residential care for the residential and non-educational costs of seriously emotionally disturbed pupils (Gov. Code, § 7581; Cal. Code Regs., tit. 2, § 60200, subd. (e))
   - Issue payments to providers of out-of-home residential facilities for the residential and non-educational costs of seriously emotionally disturbed pupils. Payments are for the costs of food, clothing, shelter, daily supervision, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation. Counties are eligible to reimbursed for 60 percent of the total residential and non-educational costs of a seriously emotionally disturbed child placed in an out-of-home residential facility.
   - Submit reports to the State Department of Social Services for reimbursement of payments issued to seriously emotionally disturbed pupils for 24-hour out-of-home care.
6. Provide psychotherapy or other mental health services, as defined in regulations, when required by the IEP (Gov. Code, § 7576; Cal. Code Regs., tit. 2, §§ 60020, subd. (a), 60200, subds. (a) and (b))
   - Provide psychotherapy or other mental health services identified in a pupil's IEP, as defined in sections 542 and 543 of the Department of Mental Health regulations. However, the activities of providing vocational services, socialization services, and crisis intervention to pupils, and dispensing medications necessary to maintain individual psychiatric stability during the treatment process, do *not* constitute a state-mandated new program or higher level of service.
7. Participate in due process hearings relating to mental health assessments or services (Gov. Code, § 7586; Cal. Code Regs., tit. 2, § 60550)

The Commission further concludes that the following revenue and/or proceeds must be identified as offsets and be deducted from the costs claimed:

- Funds received by a county pursuant to Government Code section 7576.5
- Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes funds received by a county pursuant to the $69 million appropriation to counties for purposes of this mandated program in the Budget Act of 2004 ((Stats. 2004, ch. 208, item 6110-161-0890, provision 10).
- Private insurance proceeds obtained with the consent of a parent for purposes of this program.
- Medi-Cal proceeds obtained from the state or federal government that pay a portion of the county services provided to a pupil under this mandated program in accordance with federal law.
- Any other reimbursement received from the federal or state government, or other non-local source

The period of reimbursement for this decision begins July 1, 2004.

Finally, any statutes and/or regulations that were pled in *Handicapped and Disabled Students* (CSM 4282) that are not identified above do not constitute a reimbursable state-mandated program.

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE TEST CLAIM: Government Code Sections 7570, 7571, 7572, 7572.5, 7572.55, 7573, 7576, 7579, 7582, 7584, 7585, 7586, 7586.6, 7586.7, 7587, 7588; Statutes 1984, Chapter 1747; Statutes 1985, Chapter 107; Statutes 1985, Chapter 759; Statutes 1985, Chapter 1274; Statutes 1986, Chapter 1133; Statutes 1992, Chapter 759; Statutes 1994, Chapter 1128; Statutes 1996, Chapter 654; Statutes 1998, Chapter 691; Statutes 2001, Chapter 745; Statutes 2002, Chapter 585; and Statutes 2002, Chapter 1167; and California Code of Regulations, Title 2, Sections 60000-60610; Filed on June 27, 2003 by the County of Stanislaus, Claimant; and Filed on June 30, 2003, by the County of Los Angeles, Claimant.	**Case No.: 02-TC-40/02-TC-49** ***Handicapped & Disabled Students II*** STATEMENT OF DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; CALIFORNIA CODE OF REGULATIONS, TITLE 2, DIVISION 2, CHAPTER 2.5, ARTICLE 7 (*Adopted on May 26, 2005*)

STATEMENT OF DECISION

The attached Statement of Decision of the Commission on State Mandates is hereby adopted in the above-entitled matter.

______________________________ ____________________

PAULA HIGASHI, Executive Director Date

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE TEST CLAIM:

Government Code Sections 7570, 7571, 7572, 7572.5, 7572.55, 7573, 7576, 7579, 7582, 7584, 7585, 7586, 7586.6, 7586.7, 7587, 7588;

Statutes 1984, Chapter 1747; Statutes 1985, Chapter 107; Statutes 1985, Chapter 759; Statutes 1985, Chapter 1274; Statutes 1986, Chapter 1133; Statutes 1992, Chapter 759; Statutes 1994, Chapter 1128; Statutes 1996, Chapter 654; Statutes 1998, Chapter 691; Statutes 2001, Chapter 745; Statutes 2002, Chapter 585; and Statutes 2002, Chapter 1167; and

California Code of Regulations, Title 2, Sections 60000-60610;

Filed on June 27, 2003 by the County of Stanislaus, Claimant; and

Filed on June 30, 2003, by the County of Los Angeles, Claimant.

Case No.: 02-TC-40/02-TC-49

Handicapped & Disabled Students II

STATEMENT OF DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; CALIFORNIA CODE OF REGULATIONS, TITLE 2, DIVISION 2, CHAPTER 2.5, ARTICLE 7

(*Adopted on May 26, 2005*)

STATEMENT OF DECISION

The Commission on State Mandates ("Commission") heard and decided this test claim during a regularly scheduled hearing on May 26, 2005. Leonard Kaye and Paul McIver appeared on behalf of the County of Los Angeles. Pam Stone represented and appeared on behalf of the County of Stanislaus. Linda Downs appeared on behalf of the County of Stanislaus. Nicholas Schweizer and Jody McCoy appeared on behalf of the Department of Finance

The law applicable to the Commission's determination of a reimbursable state-mandated program is article XIII B, section 6 of the California Constitution, Government Code section 17500 et seq., and related case law.

The Commission adopted the staff analysis at the hearing by a vote of 4-0.

BACKGROUND

This test claim addresses amendments to the Handicapped and Disabled Students program (also known as, Assembly Bill 3632) administered by county mental health

departments. The Handicapped and Disabled Students program was initially enacted in 1984, as the state's response to federal legislation that guaranteed disabled pupils, including those with mental health needs, the right to receive a free and appropriate public education (Individuals with Disabilities Education Act, or IDEA). Before 1984, the state adopted a comprehensive statutory scheme in the Education Code to govern the special education and related services provided to disabled children.[1] Among the related services, called "designated instruction and services" in California, the following mental health services are identified: counseling and guidance, psychological services other than the assessment and development of the IEP, parent counseling and training, health and nursing services, and social worker services.[2] The state and the local educational agencies (school districts and county offices of education) provided all related services, including mental health services, to children with disabilities.

In 1984 and 1985, the Legislature enacted Assembly Bill 3632 (Stats. 1984, ch. 1747, and Stats. 1985, ch. 1274), to shift the responsibility and funding for providing mental health services for students with disabilities from local educational agencies to county mental health departments. AB 3632 added Chapter 26.5 to the Government Code (§§ 7570 et seq.), and the Departments of Mental Health and Education adopted emergency regulations (Cal. Code Regs., tit. 2, §§ 60000-60610) to require county mental health departments to:

- Renew the interagency agreement with the local educational agency every three years and, if necessary, revise the agreement.
- Perform an initial assessment of a pupil referred by the local educational agency, and discuss assessment results with the parents and IEP team.
- Participate as a member of the IEP team whenever the assessment of a pupil determines the pupil is seriously emotionally disturbed and residential placement may be necessary.
- Act as the lead case manager, as specified in statute and regulations, if the IEP calls for residential placement of a seriously emotionally disturbed pupil.
- Issue payments to providers of out-of-home residential care for the residential and non-educational costs of seriously emotionally disturbed pupils.
- Provide psychotherapy or other mental health services, as defined in regulations, when required by the IEP.
- Participate in due process hearings relating to issues involving mental health assessments or services.

[1] Education Code section 56000 et seq. (Stats. 1980, ch. 797.)

[2] Education Code section 56363.

Past and Pending Commission Decisions on the Handicapped and Disabled Students Program

On April 26, 1990, the Commission adopted a statement of decision in *Handicapped and Disabled Students* (CSM 4282). The test claim was filed by the County of Santa Clara on Statutes 1984, chapter 1747; Statutes 1985, chapter 1274; and on California Code of Regulations, title 2, sections 60000 through 60610 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)). The Commission determined that the activities of providing mental health assessments, psychotherapy and other mental health treatment services, as well as assuming expanded IEP responsibilities, were reimbursable as a state-mandated program under article XIII B, section 6 of the California Constitution beginning July 1, 1986. Activities related to assessments and IEP responsibilities were found to be 100 per cent (100%) reimbursable. Psychotherapy and other mental health treatment services were found to be ten per cent (10%) reimbursable due to the cost sharing methodology in existence under the Short-Doyle Act for local mental health services. On January 11, 1993, the Sixth District Court of Appeal, in an unpublished decision, sustained the Commission's decision in CSM 4282.[3]

In May 2000, the Commission approved a second test claim relating to this program, *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (CSM 97-TC-05). The test claim on *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05) was filed on Government Code section 7576, as amended by Statutes 1996, chapter 654, the corresponding regulations (Cal. Code Regs, tit. 2, §§ 60100 and 60200), and on a Department of Mental Health Information Notice Number 86-29. The test claim in *Seriously Emotionally Disturbed Pupils* addressed only the counties' responsibilities for out-of-state residential placements for seriously emotionally disturbed pupils, and has a reimbursement period beginning January 1, 1997.

In addition, there are two other matters currently pending with the Commission relating to the test claim statutes and regulations. In 2001, the Counties of Los Angeles and Stanislaus filed requests to amend the parameters and guidelines on the original test claim decision, *Handicapped and Disabled Students* (CSM 4282). The counties request that the parameters and guidelines be amended to delete all references to the Short-Doyle cost-sharing mechanism for providing psychotherapy or other mental health services; to add an activity to provide reimbursement for room and board for in-state placement of pupils in residential facilities; and to amend the language regarding the reimbursement of indirect costs. The request to amend the parameters and guidelines was scheduled on the Commission's March 2002 hearing calendar. But at the request of the counties, the item was taken off calendar, and is still pending. If the Commission approves the counties'

[3] *County of Santa Clara v. Commission on State Mandates* (Jan. 11, 1993, H009520) [nonpub. Opn.]).

request to amend the parameters and guidelines, the reimbursement period for the new amended portions of the parameters and guidelines would begin on July 1, 2000.[4]

The second matter currently pending with the Commission is the reconsideration of the *Handicapped and Disabled Students* test claim (04-RL-4282-10) that was directed by Statutes 2004, chapter 493 (Sen. Bill No. 1895).

This test claim, *Handicapped and Disabled Students II*, presents the following issues:

- Does the Commission have the jurisdiction to rehear in this test claim the statutes and regulations previously determined by the Commission to constitute a reimbursable state-mandated program in *Handicapped and Disabled Students* (CSM 4282) and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05)?
- Are the test claim statutes and regulations subject to article XIII B, section 6 of the California Constitution?
- Do the test claim statutes and regulations impose a new program or higher level of service on local agencies within the meaning of article XIII B, section 6 of the California Constitution?
- Do the test claim statutes and regulations impose "costs mandated by the state" within the meaning of Government Code sections 17514 and 17556?

Claimants' Position

The claimants contend that the test claim statutes and regulations constitute a reimbursable state-mandated program within the meaning of article XIII B, section 6 of the California Constitution and Government Code section 17514.

The County of Los Angeles, according to its test claim, is seeking reimbursement for the following activities:

- Mental health assessments and related treatment services, including psychotherapy, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management.
- Placement in a residential facility outside the child's home, including the provision of food, clothing, shelter, daily supervision, school supplies, personal incidentals, liability insurance with respect to the child, and reasonable travel to the child's home for visitation.
- Due process hearings, notifications, resolution requirements.
- Preparation of interagency agreements.

The County of Stanislaus is seeking reimbursement for the activities required by statutory and regulatory amendments to the original program. The County of Stanislaus takes no position on the issue of providing residential services to the child.

[4] California Code of Regulations, title 2, section 1183.2.

The Counties of Los Angeles and Stanislaus filed comments on the draft staff analysis, which are addressed in the analysis of this claim.

Position of the Department of Finance

The Department of Finance filed comments on the test claims describing the Department's position on funding and the requested costs for residential treatment. With respect to funding, the Department contends the following:

- For claims for mental health treatment services provided before fiscal year 2000-01, eligible claimants are entitled to reimbursement for ten percent (10%) of their costs only. The Department argues that Bronzan-McCorquodale Act of 1991 was intended to replace the Short-Doyle Act, and provides ninety percent (90%) of the funding to counties for mental health treatment services for special education pupils.
- Eligible claimants are entitled to 100 per cent (100%) reimbursement for mental health treatment services beginning July 1, 2001. The Department states that section 38 of Statutes 2002, chapter 1167, increased the percentage of state reimbursement for treatment costs from ten percent (10%) to 100% for services delivered in fiscal year 2001-02 and subsequent years.

The Department of Finance states the following with respect to residential treatment costs:

> ….The [Department of Social Services (DSS)] sets reasonable board and care rates for in-state placement facilities based on specified criteria. To allow community mental health services to pay an unspecified and unregulated "patch" above and beyond the reasonable rate established by the DSS, could be extremely expensive and [would] provide no additional mental health services to the disabled child. The State would no longer be able to determine fair and reasonable placement costs. It is clear that Section 62000 [of the DSS regulations] intended that community mental health services defer to DSS when it came to board and care rate setting for in-state facilities. The state mandate process should not be used to undermine in-state rate setting for board and care in group homes.[5]

The Department of Finance filed comments on the draft staff analysis arguing that the Handicapped and Disabled Students program is federally mandated under the current federal law and that some of the activities recommended for approval do not increase the level of service required of counties and, thus, should be denied.

Position of the Department of Mental Health

The Department of Mental Health filed comments on the draft staff analysis that state in relevant part the following:

> After full review, [Department of Mental Health] wishes to state that it concurs with the comments made by the Department of Finance, but that [Department of Mental Health] has no objections, suggested

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[5] Department of Finance comments filed October 7, 2003.

modifications, or other comments regarding the submission to the Claimants.

Discussion

The courts have found that article XIII B, section 6 of the California Constitution[6] recognizes the state constitutional restrictions on the powers of local government to tax and spend.[7] "Its purpose is to preclude the state from shifting financial responsibility for carrying out governmental functions to local agencies, which are 'ill equipped' to assume increased financial responsibilities because of the taxing and spending limitations that articles XIII A and XIII B impose."[8] A test claim statute or executive order may impose a reimbursable state-mandated program if it orders or commands a local agency or school district to engage in an activity or task.[9] In addition, the required activity or task must be new, constituting a "new program," or it must create a "higher level of service" over the previously required level of service.[10]

The courts have defined a "program" subject to article XIII B, section 6, of the California Constitution, as one that carries out the governmental function of providing public services, or a law that imposes unique requirements on local agencies or school districts to implement a state policy, but does not apply generally to all residents and entities in the state.[11] To determine if the program is new or imposes a higher level of service, the test claim legislation must be compared with the legal requirements in effect immediately before the enactment of the test claim legislation.[12] A "higher level of service" occurs

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[6] Article XIII B, section 6, subdivision (a), (as amended by Proposition 1A in November 2004) provides: "Whenever the Legislature or any state agency mandates a new program or higher level of service on any local government, the State shall provide a subvention of funds to reimburse that local government for the costs of the program or increased level of service, except that the Legislature may, but need not, provide a subvention of funds for the following mandates: (1) Legislative mandates requested by the local agency affected. (2) Legislation defining a new crime or changing an existing definition of a crime. (3) Legislative mandates enacted prior to January 1, 1975, or executive orders or regulations initially implementing legislation enacted prior to January 1, 1975."

[7] *Department of Finance v. Commission on State Mandates (Kern High School Dist.)* (2003) 30 Cal.4th 727, 735.

[8] *County of San Diego v. State of California* (1997) 15 Cal.4th 68, 81.

[9] *Long Beach Unified School Dist. v. State of California* (1990) 225 Cal.App.3d 155, 174.

[10] *San Diego Unified School Dist. v. Commission on State Mandates* (2004) 33 Cal.4th 859, 878 (*San Diego Unified School Dist.)*; *Lucia Mar Unified School District v. Honig* (1988) 44 Cal.3d 830, 835-836 (*Lucia Mar*).

[11] *San Diego Unified School Dist., supra,* 33 Cal.4th 859, 874, (reaffirming the test set out in *County of Los Angeles v. State of California* (1987) 43 Cal.3d 46, 56; *Lucia Mar, supra,* 44 Cal.3d 830, 835.)

[12] *San Diego Unified School Dist., supra,* 33 Cal.4th 859, 878; *Lucia Mar, supra*, 44 Cal.3d 830, 835.

when the new “requirements were intended to provide an enhanced service to the public.”[13]

Finally, the newly required activity or increased level of service must impose costs mandated by the state.[14] -

The Commission is vested with exclusive authority to adjudicate disputes over the existence of state-mandated programs within the meaning of article XIII B, section 6.[15] In making its decisions, the Commission must strictly construe article XIII B, section 6 and not apply it as an “equitable remedy to cure the perceived unfairness resulting from political decisions on funding priorities.”[16]

Issue 1: Does the Commission have jurisdiction to rehear in this test claim the statutes and regulations previously determined by the Commission to constitute a reimbursable state-mandated program in *Handicapped and Disabled Students* (CSM 4282) and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05)?

The claimants have included the following statutes and regulations in this test claim:

- Government Code sections 7570 et seq., as added and amended by Statutes 1984, chapter 1747, and Statutes 1985, chapter, 107.
- Government Code section 7576, as amended by Statutes 1996, chapter 654.
- Sections 60000 through 60610 of the joint regulations adopted by the Departments of Mental Health and Education to implement the program. The claimants do not, however, identify the version of the regulations for which they are claiming reimbursement.

As indicated in the Background, the statutes and some of the regulations identified in the paragraph above were included in two prior test claims that the Commission approved as reimbursable state-mandated programs. In 1990, the Commission adopted a statement of decision in *Handicapped and Disabled Students* (CSM 4282) approving Government Code sections 7570 et seq., as added and amended by Statutes 1984, chapter 1747, and Statutes 1985, chapter, 107, and sections 60000 through 60610 of the emergency regulations (filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86,

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[13] *San Diego Unified School Dist., supra,* 33 Cal.4th 859, 878.

[14] *County of Fresno v. State of California* (1991) 53 Cal.3d 482, 487; *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1265, 1284 (*County of Sonoma*); Government Code sections 17514 and 17556.

[15] *Kinlaw v. State of California* (1991) 54 Cal.3d 326, 331-334; Government Code sections 17551, 17552.

[16] *County of Sonoma, supra,* 84 Cal.App.4th 1265, 1280, citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

No. 28)) as a reimbursable state-mandated program. The Legislature has directed the Commission to reconsider this decision.[17]

In 2000, the Commission adopted a statement of decision in *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05) approving Government Code section 7576, as amended by Statutes 1996, chapter 654, and the corresponding regulations (Cal. Code Regs, tit. 2, §§ 60100 and 60200) as a reimbursable state-mandated program for the counties' responsibilities for out-of-state residential placements for seriously emotionally disturbed pupils.

It is a well-settled principle of law that an administrative agency, like the Commission, does not have jurisdiction to retry a question that has become final. If a prior final decision is retried by the agency, without the statutory authority to retry or reconsider the case, that decision is void.[18]

In the present case, the Commission does not have the statutory authority to rehear in this test claim the statutes and regulations previously determined by the Commission to constitute a reimbursable state-mandated program in *Handicapped and Disabled Students* (CSM 4282) and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05).

At the time these test claims were filed, Government Code section 17521 defined a "test claim" as the first claim, including claims joined or consolidated with the first claim, filed with the Commission alleging that a particular statute or executive order imposes costs mandated by the state. The Commission's regulations allowed the filing of more than one test claim on the same statute or executive order only when (1) the subsequent test claim is filed within sixty (60) days from the date the first test claim was filed; and (2) when each test claim is filed by a different type of claimant or the issues presented in each claim require separate representation. (Cal. Code Regs., tit. 2, §§ 1183, subd. (i).) This test claim was filed more than sixty days from the date that *Handicapped and Disabled Students* (CSM 4282) and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05) were filed. In addition, all three test claims were filed by the same type of claimant; counties. There is no evidence in the record to suggest that the same statutes already determined by the Commission to constitute a reimbursable state-mandated program in the prior test claims require separate representation here.

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[17] See reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10).

[18] *Heap v. City of Los Angeles* (1936) 6 Cal.2d 405, 407, where the court held that the civil service commission had no jurisdiction to retry a question and make a different finding at a later time; *City and County of San Francisco v. Ang* (1979) 97 Cal.App.3d 673, 697, where the court held that whenever a quasi-judicial agency is vested with the authority to decide a question, such decision, when made is conclusive of the issues involved in the decision as though the adjudication had been made by the court; and *Save Oxnard Shores v. California Coastal Commission* (1986) 179 Cal.App.3d 140, 143, where the court held that in the absence of express statutory authority, an administrative agency may not change a determination made on the facts presented at a full hearing once the decision becomes final.

Finally, Government Code section 17559 grants the Commission the authority to reconsider prior final decisions only within 30 days after the Statement of Decision is issued. Since the two prior decisions in *Handicapped and Disabled Students* (CSM 4282) and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05) were adopted and issued well over 30 days ago, the Commission does not have the jurisdiction in this test claim to reconsider the same statutes and regulations pled and determined in prior test claims.

As recognized by the California Supreme Court, the purpose behind the statutory scheme and procedures established by the Legislature in Government Code section 17500 et seq. was to "avoid[] multiple proceedings, judicial and administrative, addressing the same claim that a reimbursable state mandate has been created."[19]

Therefore, the Commission does not have the jurisdiction in this test claim over the following statutes and regulations:

- The Government Code sections in Chapter 26.5 considered in *Handicapped and Disabled Students* (CSM 4282) that were added and amended by Statutes 1984, chapter 1747, and Statutes 1985, chapter, 107, and that have not been amended by the remaining test claim legislation. These statutes are Government Code sections 7571, 7572.5, 7573, 7586, 7586.7, and 7588.
- Government Code section 7576, as amended by Statutes 1996, chapter 654, as it relates to out-of-state placement of seriously emotionally disturbed pupils.
- California Code of Regulations, title 2, sections 60000 through 60610 (filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)). These regulations were repealed and were superceded by new regulations, effective July 1, 1998.[20]
- California Code of Regulations, title 2, sections 60100 and 60200 (filed as emergency regulations on July 1, 1998 (Register 98, No. 26) and refiled as final regulations on August 9, 1999 (Register 99, No. 33)) as they relate to the out-of-state placement of seriously emotionally disturbed pupils.

Issue 2: Are the test claim statutes and regulations subject to article XIII B, section 6 of the California Constitution?

<u>The activities performed by counties under the Handicapped and Disabled Students program are mandated by the state and not by federal law</u>

[19] *Kinlaw, supra*, 54 Cal.3d at page 333.

[20] See History of the regulations (Cal. Code Regs., tit. 2, §§ 60000 et seq.), notes 8 and 9.

The test claim statutes and regulations implement the federal special education law (IDEA) that requires states to guarantee to disabled pupils the right to receive a free and appropriate public education that emphasizes special education and related services designed to meet the pupil's unique educational needs.

The Department of Finance argues that the activities performed by counties under the Handicapped and Disabled Students program are federally mandated and, thus, reimbursement is not required under article XIII B, section 6 of the California Constitution. The Commission disagrees.

In 1992, the Third District Court of Appeal, in *Hayes v. Commission on State Mandates*, determined that the federal law at issue in the present case, IDEA, imposes a federal mandate on the states.[21] The *Hayes* case involved test claim legislation requiring school districts to provide special education services to disabled pupils. The school districts in the *Hayes* case alleged that the activities mandated by the state that exceeded federal law were reimbursable under article XIII B, section 6 of the California Constitution.

The court in *Hayes* determined that the state's "alternatives [with respect to federal law] were to participate in the federal program and obtain federal financial assistance and the procedural protections accorded by the act, or to decline to participate and face a barrage of litigation with no real defense and ultimately be compelled to accommodate the educational needs of handicapped children in any event."[22] The court concluded that the state had no "true choice" but to participate in the federal program and, thus, there was a federal mandate on the state.[23]

Although the court concluded that the federal law was a mandate on the states, the court remanded the case to the Commission for further findings to determine if the state's response to the federal mandate constituted a state-mandated new program or higher level of service on the school districts.[24] The court held that if the state "freely chose" to impose the costs upon the local agency as a means of implementing a federal program, then the costs are the result of a reimbursable state mandate. The court's holding is as follows:

> In our view the determination whether certain costs were imposed upon the local agency by a federal mandate must focus upon the local agency which is ultimately forced to bear the costs and how those costs came to be imposed upon that agency. *If the state freely chose to impose the costs upon the local agency as a means of implementing a federal program then the costs are the result of a reimbursable state mandate regardless whether the costs were imposed upon the state by the federal government*.[25] (Emphasis added.)

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[21] *Hayes v. Commission on State Mandates* (1992) 11 Cal.App.4th 1564, 1592.

[22] *Hayes, supra*, 11 Cal.App.4th at page 1591.

[23] *Ibid*.

[24] *Ibid*.

[25] *Id.* at page 1593-1594.

Here, pursuant to the court's holding in *Hayes*, the state "freely chose" to impose the costs upon the counties as a means of implementing the federal IDEA program.

Federal law does not require the state to impose any requirements relating to special education and related services on counties. At the time the test claim legislation was enacted, the requirements under federal law were imposed only on states and local educational agencies.[26] In 1997, Congress amended the IDEA to "strengthen the requirements on ensuring provisions of services by non-educational agencies …" (Sen. Rep. 105-17, dated May 9, 1997.) The amendment clarified that the state or local educational agency responsible for developing a child's IEP could look to non-educational agencies to pay for or provide those services the educational agencies are otherwise responsible for. The amendment further clarified that if a non-educational agency failed to provide or pay for the special education and related services, the state or local educational agency responsible for developing the IEP remain ultimately responsible for ensuring that children receive all the services described in their IEPs in a timely fashion and the state or local educational agency shall provide or pay for the services.[27] Federal law, however, does not require states to use non-educational agencies to pay for or provide services. A state's decision regarding how to implement the IDEA is still within the discretion, or the "free choice," of the state. The Department of Finance agrees with this interpretation of federal law. The Department states the following:

> While subparagraph (A) of paragraph (11) of subdivision (a) of Sec. 612 states that the state educational agency is responsible for ensuring for the provision of IDEA services, subparagraph (B) states that "[s]ubparagraph (A) shall not limit the responsibility of agencies in the State other than the State educational agency to provide, or pay for some or all of the costs of, a free appropriate public education for any child with a disability in the State." This makes clear that Federal IDEA anticipates that agencies other than educational agencies *may be* responsible for providing services and absorbing costs related to the federal legislation. Indeed, subparagraph (A) of paragraph (12) lays out specific guidelines for the assigning of responsibility for services among various agencies.
>
> DOF contends that the fact that *the state has chosen through AB 3632* and related legislation to make mental health services related to individual education plans (IEPs) the responsibility of mental health agencies does not, in and of itself, trigger mandate reimbursement through Article XIII B, section 6 as the responsibilities in question are federally mandated and

[26] Title 34 Code of Federal Regulations section 300.2.

[27] Title 20 United States Code sections 1412 (a)(12)(A), (B), and (C), and 1401 (8); Title 34 Code of Federal Regulations section 300.142. (See also, Letters from the Department of Education dated July 28, 1998 and August 2, 2004, to all SELPAs, COEs, and LEAs on the requirements of 34 C.F.R. 300.142; and *Tri-County Special Education Local Plan Area v. County of Tuolumne* (2004) 123 Cal.App.4th 563, 578, where the court stated that "it is clear the Legislature could reassign administration of IDEA programs to a different entity if it chose to do so.".)

> *federal law allows the state to choose the agency or agencies responsible for service*. (Emphasis added.)[28]

Accordingly, the activities performed by counties under the Handicapped and Disabled Students program are mandated by the state and not by federal law. Thus, the actual increased costs incurred as a result of the activities in the program that constitute a mandated new program or higher level of service are reimbursable within the meaning of article XIII B, section 6.

<u>Several test claim statutes and regulations do not mandate counties to perform an activity and, thus, are not subject to article XIII B, section 6</u>

In order for a statute or an executive order to be subject to article XIII B, section 6 of the California Constitution, the statutory language must mandate or require local governmental agencies to perform an activity or task. [29]

Here, there are several statutes included in the test claim that are helpful in understanding the Handicapped and Disabled Students program. But they do not require counties to perform an activity or task. These statutes are Government Code sections 7570, 7584, and 7587.[30]

In addition, non-substantive changes and amendments that do not affect counties were made to Government Code sections 7572, 7582, and 7585 by the test claim statutes. These amendments do not impose any state-mandated activities on counties.[31, 32]

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[28] Department of Finance comments on the draft staff analysis.

[29] *County of Fresno v. State of California* (1991) 53 Cal.3d 482, 487; *County of Los Angeles, supra,* 43 Cal.3d 46, 56; *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1264, 1283-1284; *Department of Finance, supra,* 30 Cal.4th at page 736; Gov. Code, § 17514.

[30] Government Code section 7570 provides that ensuring a free and appropriate public education for children with disabilities under federal law and the Education Code is the joint responsibility of the Superintendent of Public Instruction and the Secretary of Health and Welfare. Government Code section 7584 defines "disabled youth," "child," and "pupil." Government Code section 7587 requires the Departments of Education and Mental Health to adopt regulations to implement the program.

[31] Government Code section 7572, as originally added in 1984 and amended in 1985, addresses the assessment of a student, including psychological and other mental health assessments performed by counties. The 1992 amendments to Government Code section 7572 substituted the word "disability" for "handicap," and made other clarifying, non-substantive amendments. Government Code section 7582 states that assessments and therapy treatment services provided under the program are exempt from financial eligibility standards and family repayment requirements. The 1992 amendment to section 7582 substituted "disabled child or youth" for "handicapped child." Government Code section 7585 addresses the notification of an agency's failure to provide a required service and reports to the Legislature. The 2001 amendments to section 7585 corrected the spelling of "administrative" and deleted the requirement for the Superintendent of

Furthermore, the Commission finds that Government Code section 7579, as amended by the test claim legislation, does not impose any state-mandated duties on county mental health departments. As originally enacted, Government Code section 7579 required courts, regional centers for the developmentally disabled, or other non-educational public agencies that engage in referring children to, or placing children in, residential facilities, to notify the administrator of the special education local plan area (SELPA) in which the residential facility is located before the pupil is placed in an out-of-home residential facility. The intent of the legislation, as stated in subdivision (c), was to "encourage communication between the courts and other public agencies that engage in referring children to, or placing children in, residential facilities, and representatives of local educational agencies."

The 2002 test claim statute (Stats. 2002, ch. 585) amended Government Code section 7579 by adding subdivision (d), to require public agencies other than educational agencies that place a child in a residential facility located out of state, without the involvement of a local educational agency, to assume responsibility for educational and non-educational costs of the child. Government Code section 7579, subdivision (d), states the following:

> Any public agency other than an educational agency that places a disabled child or child suspected of being disabled in a facility out of state without the involvement of the school district, SELPA, or COE [county office of education] in which the parent or guardian resides, shall assume financial responsibility for the child's residential placement, special education program, and related services in the other state unless the other state or its local agencies assume responsibility.

Government Code section 7579, subdivision (d), however, does not apply to county mental health departments. The duty imposed by section 7579 to pay the educational and non-educational costs of a child placed in an out-of-state residential facility is a duty imposed on a placing agency, like a court or a regional center for the developmentally

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Public Instruction and the Secretary of Health and Welfare to submit yearly reports to the Legislature on the failure of an agency to provide a required service.

[32] The County of Los Angeles, in comments to the draft staff analysis for this test claim, addresses a finding made on the reconsideration of the original *Handicapped and Disabled Students* claim (04-RL-4282-10), relating to Government Code section 7572 and the counties' attendance at IEP meetings following a mental health assessment of a pupil. The County's comments are not relevant to this test claim, however. The language in Government Code section 7572 relating to the county's attendance at an IEP meeting following an assessment was added by the Legislature in 1985. As indicated in the analysis, the Commission does not have jurisdiction in this test claim to address the statutes or activities originally added by the Legislature in 1984 and 1985. The Commission does have jurisdiction in this test claim over Government Code section 7572, as amended by Statutes 1992, chapter 759. But the 1992 amendments to section 7572 were non-substantive and do not impose any additional state-mandated activities on counties.

disabled, that fails to seek the involvement of the local educational agency. This consolidated test claim has been filed on behalf of county mental health departments.[33]

This conclusion is further supported by section 60510 of the regulations. Section 60510 of the regulations was adopted in 1998 (filed as an emergency regulation on July 1, 1998 (Register 98, No. 26) and refiled as a final regulation on August 9, 1999 (Register 99, No. 33)) to implement Government Code section 7579. The regulation requires "the court, regional center for the developmentally disabled, or public agency other than an educational agency" to notify the SELPA director before placing a child in a facility and requires the agency to provide specified information to the SELPA. Section 60510 is placed in article 7 of the regulations dealing with the exchange of information between "Education and Social Services." Article 7 is separate and apart from, and located after, the regulations addressing mental health related services. Accordingly, the Commission finds that Government Code section 7579, and section 60510 of the regulations, do not impose any state-mandated duties on county mental health departments.

Finally, the County of Stanislaus requests reimbursement for section 60400 of the regulations (filed as an emergency regulation on July 1, 1998 (Register 98, No. 26) and refiled as a final regulation on August 9, 1999 (Register 99, No. 33)). Section 60400, on its face, does not mandate any activities on counties. Rather, section 60400 of the regulations addresses the requirement imposed on the Department of Health Services to provide the services of a home health aide when the local educational agency considers a less restrictive placement from home to school for a pupil. The statutory authority and reference for this regulation is Government Code section 7575, which requires the Department of Health Services, "*or any designated local agency administering the California Children's Services*," to be responsible for occupational therapy, physical therapy, and the services of a home health aide, as required by the IEP. The claimants, however, did not plead Government Code section 7575 in their test claims. In addition, there is no evidence in the record that local agencies administering the California Children's Services program have incurred increased costs mandated by the state. Accordingly, the Commission finds that section 60400 of the regulations does not impose any state-mandated activities on county mental health departments.

Accordingly, Government Code sections 7570, 7572, 7579, 7582, 7584, 7585, and 7587, as amended by the test claim legislation, and sections 60400 and 60510 of the regulations do not impose state-mandated duties on counties and, thus, are not subject to article XIII B, section 6 of the California Constitution.

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[33] The declarations submitted by the claimants here are from the county mental health departments. (See declaration of Paul McIver, District Chief, Department of Mental Health, County of Los Angeles; and declaration of Dan Souza, Mental Health Director for the County of Stanislaus.)

The remaining test claim statutes and regulations constitute a "program" within the meaning of article XIII B, section 6

The remaining test claim statutes and regulations consist of the following:

- Government Code sections 7572.55 (as added in 1994), and 7576 and 7586.6 (as amended in 1996); and
- With the exception of sections 60400 and 60510 of the regulations, the joint regulations adopted by the Departments of Mental Health and Education (Cal. Code Regs, tit. 2, §§ 60000 et seq.), which took effect as emergency regulations on July 1, 1998 (Register 98, No. 26) and became final on August 9, 1999 (Register 99, No. 33).

In order for the test claim statutes and regulations to be subject to article XIII B, section 6 of the California Constitution, the statutes and regulations must constitute a "program." The California Supreme Court, in the case of *County of Los Angeles* v. *State of California*[34], defined the word "program" within the meaning of article XIII B, section 6 as a program that carries out the governmental function of providing a service to the public, or laws which, to implement a state policy, impose unique requirements on local governments and do not apply generally to all residents and entities in the state. Only one of these findings is necessary to trigger the applicability of article XIII B, section 6.[35]

The test claim statutes and regulations involve the special education and related services provided to pupils. In 1988, the California Supreme Court held that education of handicapped children is "clearly" a governmental function providing a service to the public.[36] Thus, the remaining test claim statutes and regulations qualify as a program that is subject to article XIII B, section 6 of the California Constitution.

Issue 3: Do the remaining test claim statutes and regulations impose a new program or higher level of service on local agencies within the meaning of article XIII B, section 6 of the California Constitution?

This test claim addresses the statutory and regulatory changes made to the existing Handicapped and Disabled Students program. The courts have defined a "higher level of service" in conjunction with the phrase "new program" to give the subvention requirement of article XIII B, section 6 meaning. "Thus read, it is apparent that the subvention requirement for increased or higher level of service is directed to state-mandated increases in the services provided by local agencies in existing programs."[37] A statute or executive order imposes a reimbursable "higher level of service" when the statute or executive order, as compared to the legal requirements in effect immediately

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[34] *County of Los Angeles, supra,* 43 Cal.3d 46, 56.

[35] *Carmel Valley Fire Protection Dist., supra*, 190 Cal.App.3d at 537.

[36] *Lucia Mar Unified School District, supra*, 44 Cal.3d at page 835.

[37] *County of Los Angeles, supra*, 43 Cal.3d at page 56; *San Diego Unified School District, supra*, 33 Cal.4th at page 874.

before the enactment of the test claim legislation, increases the actual level of governmental service provided in the existing program.[38]

As indicated above, the original statutes in Chapter 26.5 of the Government Code were added by the Legislature in 1984 and 1985. In addition, pursuant to the requirements of Government Code section 7587, the Departments of Mental Health and Education adopted the first set of emergency regulations for the program in 1986. Although the history of the regulations states that the first set of emergency regulations were repealed on June 30, 1997, by operation of Government Code section 7587, and that a new set of regulations were not operative until one year later (July 1, 1998), the Commission finds, as described below, that the initial set of emergency regulations remained operative after the June 30, 1997 deadline, until the new set of regulations became operative in 1998. Thus, for purposes of analyzing whether the remaining test claim legislation constitutes a new program or higher level of service, the initial emergency regulations, and the 1984 and 1985 statutes in Chapter 26.5 of the Government Code, constitute the existing law in effect immediately before the enactment of the test claim legislation.

Government Code section 7587 required the Departments of Mental Health and Education to adopt emergency regulations by January 1, 1986, to implement the Handicapped and Disabled Students program. The statute, as amended in 1996 (Stats. 1996, ch. 654), further states that the emergency regulations "shall not be subject to automatic repeal until the final regulations take effect on or before June 30, 1997." Section 7587 states, in relevant part, the following:

> …For the purposes of the Administrative Procedure Act, *the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare*. These regulations shall not be subject to the review and approval of the Office of Administrative Law and *shall not be subject to automatic repeal until the final regulations take effect on or before June 30, 1997*, and the final regulations shall become effective immediately upon filing with the Secretary of State. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments. (Emphasis added.)

The final regulations were not adopted by the June 30, 1997 deadline. Nevertheless, the courts have interpreted the time limits contained in statutes similar to Government Code section 7587 as directory and not mandatory. When a deadline in a statute is deemed directory, then the action required by the statute remains valid.[39] The California Supreme Court describes the general rule of interpretation as follows:

> Time limits are usually deemed to be directory unless the Legislature clearly expresses a contrary intent. [Citation omitted.] "In ascertaining

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[38] *San Diego Unified School Dist., supra,* 33 Cal.4th 859, 878; *Lucia Mar, supra*, 44 Cal.3d 830, 835.

[39] *California Correctional Peace Officers Association v. State Personnel Board* (1995) 10 Cal.4th 1133, 1145.

> probable intent, California courts have expressed a variety of tests. In some cases focus has been directed at the likely consequences of holding a particular time limitation mandatory, in an attempt to ascertain whether those consequences would defeat or promote the purpose of the enactment. . . .Other cases have suggested that a time limitation is deemed merely directory 'unless a consequence or penalty is provided for failure to do the act within the time commanded. [Citation omitted.] As *Morris v. County of Marin* [citation omitted] held, the consequence or penalty must have the effect of invalidating the government action in question if the limit is to be characterized as "mandatory."[40]

As determined by the California Supreme Court, time limits are usually deemed directory unless a contrary intent is expressly provided by the Legislature or there is a penalty for not complying with the deadline. In the present case, the plain language of Government Code section 7587 does *not* indicate that the Legislature intended the June 30, 1997 deadline to be mandatory, thus making the regulations invalid on that date. If that was the case, the state would be acting contrary to federal law by not having procedures in place for one year regarding the assessment, special education, and related services of a child suspected of needing mental health services necessary to preserve the child's right under federal law to receive a free and appropriate public education.[41] Instead, the plain language of the statute expresses the legislative intent that the regulations are "deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare." This language supports the conclusion that the Legislature intended the original regulations to remain valid until new regulations were adopted.

This conclusion is further supported by the actions of the affected parties after the June 30, 1997 deadline. In 1998, individual plaintiffs filed a lawsuit seeking a writ of mandate directing the Departments of Mental Health and Education to adopt final regulations in accordance with Government Code section 7587.[42] As indicated in the petition for writ of mandate, the plaintiffs asserted that the original emergency regulations were enforced and applied after the June 30, 1997 deadline, that the Office of

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[40] *Ibid.*

[41] The requirements of the federal special education law (the Individuals with Disabilities Education Act (IDEA)) have been determined to constitute a federal mandate on the states. (*Hayes v. Commission on State Mandates* (1992) 11 Cal.App.4th 1564, 1592.) Under federal law, states are required to provide specially designed instruction, at no cost to the parent, to meet the unique needs of a disabled pupil, including classroom instruction and related services, according to the pupil's IEP. (U.S.C., tit. 20 §§ 1400 et seq.; 34 C.F.R. § 300.343.) Related services include psychological services. (34 C.F.R. § 300.24.) Pursuant to federal regulations on the IEP process, the pupil must be evaluated in all areas of suspected disabilities by a multidisciplinary team. (34 C.F.R. § 300.502.)

[42] *McLeish and Ryan v. State Department of Education, et al.*, Sacramento Superior Court, Case No. 96CS01380.

Administrative Law did not provide notice of repeal of the regulations, and that the original emergency regulations were never deleted from the California Code of Regulations.[43] Ultimately, the parties stipulated to a judgment and writ that subsequent emergency regulations would be filed on or before July 1, 1998, to supercede the original emergency regulations, and that on or before September 24, 1999, the final regulations would be in full force and effect.[44] Thus, the parties affected by the original emergency regulations continued to act as if the regulations were still in effect.

Therefore, the Commission finds that the initial set of emergency regulations remained operative after the June 30, 1997 deadline, until the new set of regulations became operative in 1998. Thus, for purposes of analyzing whether the remaining test claim legislation constitutes a new program or higher level of service, there is no time gap between the original emergency regulations and the subsequent regulations adopted in July 1998. The initial emergency regulations, and the 1984 and 1985 statutes in Chapter 26.5 of the Government Code, constitute the valid, existing law in effect immediately before the enactment of the test claim legislation.

Accordingly, the issue before the Commission is whether the remaining test claim legislation [Gov. Code, § 7572.55, as added in 1994, and §§ 7576 and 7586.6, as amended in 1996, and the joint regulations adopted by the Departments of Mental Health and Education (Cal. Code Regs, tit. 2, §§ 60000 et seq.), which took effect as emergency regulations on July 1, 1998 (Register 98, No. 26) and became final on August 9, 1999 (Register 99, No. 33)] imposes a new program or higher level of service when compared to the legal requirements in effect immediately before the enactment of the test claim legislation, by increasing the actual level of governmental service provided in the existing program.

A. Interagency Agreements (Gov. Code, § 7586.6; Cal. Code Regs., tit. 2, § 60030)

Government Code section 7586.6

Government Code section 7586.6 was added by the test claim legislation in 1996 to address, in part, the interagency agreements between counties and local educational agencies. Government Code section 7586.6, subdivision (b), states the following:

> It is the intent of the Legislature that the designated local agencies of the State Department of Education and the State Department of Mental Health update their interagency agreements for services specified in this chapter at the earliest possible time. It is the intent of the Legislature that the state and local interagency agreements be updated at least every three years or earlier as necessary.

The plain language of Government Code section 7586.6, subdivision (b), states the "legislative intent" that the local interagency agreements be updated at least every three years or earlier as necessary.

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[43] See Petition for Writ of Mandamus, paragraphs 42 and 43, *McLeish, supra*.

[44] See Writ of Mandamus, *McLeish, supra*.

The Commission finds that Government Code section 7586.6 does not impose a new program or higher level of service. Even if legislative intent were determined to constitute a mandated activity, updating or renewing the interagency agreements every three years is not new and the level of service required of counties is not increased. Under prior law, former section 60030, subdivision (a)(2), of the regulations adopted by the Departments of Mental Health and Education required the local mental health director[45] and the county superintendent of schools to renew, and revise if necessary, the interagency agreements every three years or at any time the parties determine a revision is necessary.

Accordingly, the Commission finds that Government Code section 7586.6 does not impose a new program or higher level of service.

<u>California Code of Regulations, title 2, section 60030</u>

Section 60030 of the joint regulations governs the interagency agreements between counties and local educational agencies. Under prior law, the original emergency regulations required the development of an interagency agreement that included "a delineation of the process and procedure" for the following nine (9) items:

- Interagency referrals of pupils, which minimize time line delays. This may include written parental consent on the receiving agency's forms.
- Timely exchange of pupil information in accordance with applicable procedures ensuring confidentiality.
- Participation of mental health professionals, including those contracted to provide services, at IEP team meetings pursuant to Government Code sections 7572 and 7576.
- Developing or amending the mental health related service goals and objectives, and the frequency and duration of such services indicated on the pupil's IEP.
- Transportation of individuals with exceptional needs to and from the mental health service site when such service is not provided at the school.
- Provision by the school of an assigned, appropriate space for delivery of mental health services or a combination of education and mental health services to be provided at the school.
- Continuation of mental health services during periods of school vacation when required by the IEP.
- Identification of existing public and state-certified nonpublic educational programs, treatment modalities, and location of appropriate residential placements, which may be used for placement by the expanded IEP program team.

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[45] Local mental health director is defined as "the officer appointed by the governing body of a county to manage a community mental health service." (Cal. Code Regs., tit. 2, § 60020, subd. (e).)

- Out-of-home placement of seriously emotionally disturbed pupils in accordance with the educational and treatment goals on the IEP.[46]

In addition, former section 60100, subdivision (a), of the regulations required the local mental health program and the SELPA liaison to define the process and procedures for coordinating services to promote alternatives to out-of-home care of seriously emotionally disturbed pupils. These requirements remain the law.

Section 60030 of the regulations, as replaced by the test claim legislation in 1998, now requires that the interagency agreement include a "delineation of the procedures" for seventeen (17) items. In this regard, section 60030, subdivision (c), requires that the following additional eight (8) procedures be identified in the interagency agreement:

- Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code section 7575, subdivision (f). For purposes of this subdivision only, the term "appropriate" means any service identified in the pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(2).)
- A host county[47] to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)
- Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)
- At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)
- The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)
- The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)

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[46] Former California Code of Regulations, title 2, section 60030, subdivision (b).

[47] A "host county" is defined to mean the county where the pupil with a disability is living when the pupil is not living in the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (d).) The "county of origin" is defined as the county in which the parent of the pupil with disability resides. If the pupil is a ward or dependent of the court, an adoptee receiving adoption assistance, or a conservatee, the county of origin is the county where this status currently exists. (Cal. Code Regs., tit. 2, § 60020, subd. (b).)

- The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)
- Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)

According to the final statement of reasons prepared by the Departments of Education and Mental Health for the regulations, the section on interagency agreements was "expanded because experience in the field has shown that many local interagency agreements are not effective." The final statement of reasons further states that the regulation "requires stronger interagency agreements in order to improve local agencies' ability to adhere to the timelines required by law."[48]

Since the interagency agreement must now contain additional information, the Commission finds that section 60030 of the regulations imposes a new program or higher level of service for the one-time activity of revising the interagency agreement with each local educational agency to include the following eight procedures:

- Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code section 7575, subdivision (f). For purposes of this subdivision only, the term "appropriate" means any service identified in the pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(2).)
- A host county to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)
- Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)
- At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)
- The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)
- The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)

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[48] Final Statement of Reasons, pages 10-11.

- The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)
- Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)[49]

B. Referral and Mental Health Assessment of a Pupil (Gov. Code, § 7576; Cal. Code Regs., tit. 2, §§ 60040, 60045)

Government Code section 7576, as amended by the 1996 test claim statute (Stats. 1996, ch. 654), and sections 60040 and 60045 of the regulations govern the referral of a pupil suspected of needing mental health services to the county for an assessment. Under prior law, Government Code section 7572 and former section 60040 of the regulations required counties to perform the following referral and assessment activities:

- Review the following educational information of a pupil referred to the county by a local education agency for an assessment: a copy of the assessment reports completed in accordance with Education Code section 56327, current and relevant behavior observations of the pupil in a variety of educational and natural settings, a report prepared by personnel that provided "specialized" counseling and guidance services to the pupil and, when appropriate, an explanation why such counseling and guidance will not meet the needs of the pupil.
- If necessary, observe the pupil in the school environment to determine if mental health assessments are needed.
- If mental health assessments are deemed necessary by the county, develop a mental health assessment plan and obtain the parent's written informed consent for the assessment.
- Assess the pupil within the time required by Education Code section 56344.

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[49] The Counties of Los Angeles and Stanislaus, in comments to the draft staff analysis, argue that revising the interagency agreement in accordance with section 60030 of the regulations is not a one-time activity. The County of Los Angeles argues "the negotiation, development, and periodic revision and review of Interagency Agreements require a variety of time consuming activities over an extended period of time." The County of Stanislaus contends that the interagency agreement is a living, breathing document. However, as indicated in the analysis, periodic renewal and revision of the agreements, which are ongoing activities, are not new. Counties were required to perform these activities every three years under the prior regulations. (Former Cal. Code Regs., tit. 2, § 60030.) Reimbursement for the ongoing activities of renewing the interagency agreements every three years and revising if necessary are addressed in the reconsideration of the original *Handicapped and Disabled Students* program (04-RL-4282-10).

- If a mental health assessment cannot be completed within the time limits, provide notice to the IEP team administrator or designee no later than 15 days before the scheduled IEP meeting.
- Prepare and provide to the IEP team, and the parent or guardian, a written assessment report in accordance with Education Code section 56327. The report shall include the following information: whether the pupil may need special education and related services; the basis for making the determination; the relevant behavior noted during the observation of the pupil in the appropriate setting; the relationship of that behavior to the pupil's academic and social functioning; the educationally relevant health and development, and medical findings, if any; for pupils with learning disabilities, whether there is such a discrepancy between achievement and ability that it cannot be corrected without special education and related services; a determination concerning the effects of environmental, cultural, or economic disadvantage, where appropriate; and the need for specialized services, materials, equipment for pupils with low incidence disabilities.
- Review and discuss the county recommendation with the parent and the appropriate members of the IEP team before the IEP team meeting.
- In cases where the local education agency refers a pupil to the county for an assessment, attend the IEP meeting if requested by the parent.
- Review independent assessments of a pupil obtained by the parent.
- Following review of the independent assessment, discuss the recommendation with the parent and with the IEP team before the meeting of the IEP team.
- In cases where the parent has obtained an independent assessment, attend the IEP team meeting if requested.

These activities are still required by law. However, the test claim legislation requires counties to perform additional activities. For example, Government Code section 7576, subdivision (b)(1), mandates a new program or higher level of service by requiring the county and the local educational agency to "work collaboratively to ensure that assessments performed *prior to referral* are as useful as possible to the community mental health service [i.e., the county] in determining the need for mental health services and the level of services needed." (Emphasis added.)

In addition, Government Code section 7576, subdivision (g), and section 60040, subdivision (g), mandate a new program or higher level of service by requiring a county that receives a referral for a pupil with a different county of origin, to forward the referral within one working day to the county of origin. The county of origin shall then have the programmatic and fiscal responsibility for providing or arranging for the provision of necessary services for the pupil.

Furthermore, section 60045 of the regulations addresses the assessment of a pupil and imposes new, required activities on counties. Under prior law, counties were required to determine if a mental health assessment of a pupil is necessary. (Former Cal. Code Regs., tit. 2, § 60040, subd. (d).) Section 60045 retains that requirement, and also

requires that if the county determines that a mental health assessment is not necessary, the county shall document the reasons and notify the parents and local educational agency of the county determination within one working day. (Cal. Code Regs., tit. 2, § 60045, subd. (a)(1).)

Section 60045, subdivision (a)(2), now requires that if the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral.

Section 60045, subdivision (b), provides that "if a mental health assessment is determined to be necessary," the community mental health service shall notify the local educational agency, develop a mental health assessment plan, and provide the plan and a consent form to the parent." Under prior law, counties were required to develop a mental health assessment plan and provide a consent form for the assessment to the parent. (Former Cal. Code Regs., tit. 2, § 60040, subd. (d).) However, the activities to notify the local educational agency when an assessment is determined necessary, and to provide the assessment plan to the parent are new activities.

Although section 60045, subdivisions (a) and (b), includes language that implies that the activities are within the discretion of the county (e.g., the activity is required "if no mental health assessment is determined necessary"), the Commission finds that these activities are mandated by the state when necessary to provide the pupil with a free and appropriate education under federal law. Under the rules of statutory construction, section 60045, subdivisions (a) and (b), must be interpreted in the context of the entire statutory scheme so that the statutory scheme may be harmonized and have effect.[50] In addition, it is presumed that the administrative agency, like the Departments of Mental Health and Education, did not adopt a regulation that alters the terms of a legislative enactment.[51] Federal law, through the IDEA, requires the state to *identify*, locate, and evaluate *all* children with disabilities, including children attending private schools, who are in need of special education and related services.[52] The state is also required by federal law to conduct a full and individual initial evaluation to determine whether a child has a qualifying disability, and the educational needs of the child.[53] In addition, Government Code section 7572, subdivision (a), requires that a child shall be assessed in all areas related to the suspected handicap by those qualified to make a determination of the child's need for the service. In cases where the pupil is suspected of needing mental health services, the state has delegated to the counties the activity of assessing the need for service. Accordingly, the Commission finds that the section 60045, subdivisions (a) and (b), mandate the following new activities that constitute a new program or higher level of service:

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[50] *Select Base Materials v. Board of Equalization* (1959) 51 Cal.2d 640, 645; *City of Merced v. State of California* (1984) 153 Cal.App.3d 777, 781-782.

[51] *Wallace v. State Personnel Board* (1959) 168 Cal.App.2d 543, 547.

[52] 20 United States Code section 1412, subdivision (a)(3).

[53] 20 United States Code section 1414, subdivision (a).

- If the county determines that a mental health assessment is not necessary, the county shall document the reasons and notify the parents and local educational agency of the county determination within one working day.
- If the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral.
- Notify the local educational agency when an assessment is determined necessary.
- Provide the assessment plan to the parent.

Furthermore, section 60045, subdivision (c), requires counties to perform a new activity to "report back to the referring [local educational agency] or IEP team within 30 days from the date of the receipt of the referral . . . if no parental consent for a mental health assessment has been obtained." The Commission finds this activity constitutes a new program or higher level of service.

The Commission further finds that section 60045, subdivision (d), mandates a new program or higher level of service on counties by requiring counties to notify the local educational agency within one working day after receipt of the parent's written consent for the mental health assessment to establish the date of the IEP meeting. This activity was not required under prior law.

The Commission also finds that section 60045, subdivision (f)(1), mandates a new program or higher level of service on counties by requiring counties to provide the parent with written notification that the parent may require the assessor to attend the IEP meeting to discuss the recommendation when the parent disagrees with the assessor's mental health service recommendation. As enacted before the test claim legislation, Government Code section 7572, subdivision (d)(1), requires that the parent be notified in writing of this parental right. But Government Code section 7572, subdivision (d)(1), does not specify the agency that is required to provide the written notice. Thus, section 60045, subdivision (f)(1), delegates the responsibility to the county.

Finally, section 60045, subdivision (h), mandates a new program or higher level of service by requiring the county of origin to prepare statutorily required IEP reassessments. Pursuant to federal law, yearly reassessments are required to determine the needs of the pupil.[54]

C. Transfers and Interim Placements (Cal. Code Regs., tit. 2, § 60055)

The Departments of Education and Mental Health adopted a new regulation in section 60055 to address the interim placement of a pupil receiving mental health services pursuant to an existing IEP following the pupil's transfer to a new school district. Section 60055 states the following:

> (a) Whenever a pupil who has been receiving mental health services, pursuant to an IEP, transfers into a school district from a school district in another county, the responsible LEA [local educational

[54] 34 Code of Federal Regulations, section 300.343.

agency] administrator or IEP team shall refer the pupil to the local community mental health service [county] to determine appropriate mental health services.

(b) The local mental health director or designee shall ensure that the pupil is provided interim mental health services, as specified in the existing IEP, pursuant to Section 56325 of the Education Code, for a period not to exceed thirty (30) days, unless the parent agrees otherwise.

(c) An IEP team, which shall include an authorized representative of the responsible community mental health service, shall be convened by the LEA to review the interim services and make a determination of services within thirty (30) days of the pupil's transfer.

According to the final statement of reasons, section 60055 "conforms with and implements Education Code section 56325 which ensures that special education pupils continue to receive services after they transfer into a new school district or SELPA. This section is intended to address implementation problems in these situations reported by the field in which eligible pupils were denied services due to an inter-county transfer."[55]

The Commission finds that section 60055 mandates a new program or higher level of service on counties, following a pupil's transfer to a new school district, by requiring them to perform the following activities:

- Provide interim mental health services, as specified in the existing IEP, for thirty days, unless the parent agrees otherwise.
- Participate as a member of the IEP team of a transfer pupil to review the interim services and make a determination of services.

D. Participate as a Member of the IEP Team When Residential Placement of a Pupil is Recommended (Gov. Code, § 7572.55; Cal. Code Regs., tit. 2, § 60100)

Under existing law, when a child is assessed as seriously emotionally disturbed and any member of the IEP team recommends residential placement, the IEP team shall be expanded to include a representative of the county. The expanded IEP team is required to review the assessment and determine whether: (1) the child's needs can reasonably be met through any combination of nonresidential services, preventing the need for out-of-home care; (2) residential care is necessary for the child to benefit from educational services; and (3) residential services are available, which address the needs identified in the assessment and which will ameliorate the conditions leading to the seriously emotionally disturbed designation. The expanded IEP team is also required to consider all possible alternatives to out-of-home placement. (Gov. Code, § 7572.5, former Cal. Code Regs, tit. 2, § 60100.) Finally, the expanded IEP team is required to document the

[55] Final Statement of Reasons, page 20.

pupil's educational and mental health treatment needs that support the recommendation for the placement. (Former Cal. Code Regs, tit. 2, § 60100, subd. (e).)

These activities remain the law and counties are currently eligible for reimbursement for their participation on the expanded IEP team.[56] However, the test claim legislation amended the law with respect to the activities performed by the expanded IEP team.

In 1994, the Legislature added section 7572.55 to the Government Code (Stats. 1994, ch. 1128). Government Code section 7572.55, subdivision (c), requires the expanded IEP team, when a recommendation is made that a child be placed in an *out-of-state* residential facility, to develop a plan for using less restrictive alternatives and in-state alternatives as soon as they become available, unless it is in the best educational interest of the child to remain in the out-of-state school.

In addition, section 60100 of the regulations, as adopted in 1998, requires the expanded IEP team to perform the following activities:

- The expanded IEP team shall document the alternatives to residential placement that were considered and the reasons why they were rejected. (Cal. Code Regs., tit. 2, § 60100, subd. (c).)
- The expanded IEP team shall ensure that placement is in accordance with admission criteria of the facility. (Cal. Code Regs., tit. 2, § 60100, subd. (j).)

The Department of Finance contends that these activities performed by the expanded IEP team do not constitute a new program or higher level of service. The Department states the following:

> It is our interpretation that there is no meaningful difference between the requirements under the prior regulations and the new regulations with respect to identifying, analyzing, and documenting all alternatives to residential placement. The existing activities of considering "all possible alternatives to out-of-home placement" and documenting "the pupil's educational and mental health treatment needs that support the recommendation for the placement" would already include the development of a plan for using less restrictive and in-state alternatives and documentation of the reasons why these alternatives were rejected. It is not clear that the new requirements cited above impose a new or higher level of service.[57]

[56] For this reason, the Commission agrees with a comments filed by the Counties of Los Angeles and Stanislaus on the draft staff analysis that the county's participation on the expanded IEP team occurs when there is a recommendation for out-of-home placement, regardless of whether the recommendation is for a facility in the state or a facility out of the state. This test claim, however, addresses only the new activities required by the Government Code sections and regulations for which the Commission has jurisdiction (i.e., Gov. Code, § 7572.55, as added by Stats. 1994, ch. 1128, and the 1998 regulations.)

[57] Department of Finance comments to the draft staff analysis.

The Commission disagrees. First, the activity required by Government Code section 7572.55, subdivision (c), to develop a plan for using less restrictive alternatives and in-state alternatives when a recommendation is made that a child be placed in an out-of-state facility, is a new requirement. Government Code section 7572.55 was *added* by the test claim legislation. Under prior law, the expanded IEP team was only required to "consider" all possible alternatives to residential placement. The express language of prior law did not require the expanded IEP team to develop a plan for using less restrictive alternatives specifically for out-of-state placements. Thus, the Commission finds that Government Code 7572.55, subdivision (c), imposes a new program or higher level of service with regard to the counties' participation on the expanded IEP team.

The Commission further finds that the two activities mandated by section 60100 are new activities, not required under prior law. Section 60100, subdivision (c), requires the expanded IEP team to document the alternatives to residential placement that were considered and the reasons why they were rejected. Under prior law, the expanded IEP team was required to "consider" all possible alternatives to residential placement. Prior law also required the expanded IEP team to document the pupil's educational and mental health treatment needs that support the final recommendation for the placement. But prior law did not require the expanded IEP team to document the alternatives to residential placement that were considered by the team and the reasons why the alternatives were rejected. Thus, the Commission finds that section 60100, subdivision (c), imposes a new program or higher level of service.

Moreover, the Commission finds that the activity required by section 60100, subdivision (j), imposes a new program or higher level of service by requiring, for the first time, that the expanded IEP team ensure that placement is in accordance with admission criteria of the facility.

Finally, when the expanded IEP team determines that it is necessary to place a pupil who is seriously emotionally disturbed in residential care, counties are now required to ensure that: (1) the mental health services are specified in the IEP in accordance with federal law; and (2) the mental health services are provided by qualified mental health professionals.[58] (Cal. Code Regs., tit. 2, § 60100, subd. (i).) Counties were not required to perform these activities under prior law. Therefore, the Commission finds that the activities required by section 60100, subdivision (i), constitute a new program or higher level of service.

E. Case Management Duties for Pupils Placed in Residential Care (Cal. Code Regs., tit. 2, §§ 60100, 60110)

Under existing law, Government Code section 7572.5, subdivision (c)(1), requires the county to act as the lead case manager if the review of the expanded IEP team calls for residential placement of the seriously emotionally disturbed pupil. The statute further

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[58] Section 60020 defines "qualified mental health professional" to include the following licensed practitioners of the healing arts: a psychiatrist; psychologist; clinical social worker; marriage, family and child counselor; registered nurse, mental health rehabilitation specialist, and others who have been waivered under Welfare and Institutions Code section 5751.2.

requires that "the mental health department shall retain financial responsibility for provision of case management services." Former section 60110, subdivision (a), required the following case management duties:

- Convene parents and representatives of public and private agencies in accordance with section 60100, subdivision (f), in order to identify the appropriate residential facility.
- Complete the local mental health program payment authorization in order to initiate out of home care payments.
- Coordinate the completion of the necessary County Welfare Department, local mental health program, and responsible local education agency financial paperwork or contracts.
- Develop the plan for and assist the family and pupil in the pupil's social and emotional transition from home to the residential facility and the subsequent return to the home.
- Facilitate the enrollment of the pupil in the residential facility.
- Conduct quarterly face-to-face contacts with the pupil at the residential facility to monitor the level of care and supervision and the implementation of the treatment services and the IEP.
- Notify the parent or legal guardian and the local education agency administrator or designee when there is a discrepancy in the level of care, supervision, provision of treatment services, and the requirements of the IEP.
- Coordinate the six-month expanded IEP team meeting with the local education agency administrator or designee.

Sections 60100 and 60110 of the regulations, as adopted in 1998, require county case managers to perform the following new activities not required under prior law:

- Coordinate the residential placement plan of a pupil with a disability who is seriously emotionally disturbed as soon as possible after the decision has been made to place the pupil in residential placement. The residential placement plan shall include provisions, as determined in the pupil's IEP, for the care, supervision, mental health treatment, psychotropic medication monitoring, if required, and education of the pupil. (Cal. Code Regs., tit, 2, § 60110, subd, (b)(1).)[59]
- When the IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a community treatment facility, the lead case manager shall ensure that placement is in accordance with

[59] Although the regulation requires the county case manager to plan for the educational needs of a pupil placed in a residential facility, the local educational agency is ultimately responsible for "providing or arranging for the special education and non-mental health related services needed by the pupil. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(2); Final Statement of Reasons, p. 24.)

admission, continuing stay, and discharge criteria of the community treatment facility. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(3).)[60]

- Identify, in consultation with the IEP team's administrative designee, a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost-effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment. (Cal. Code Regs, tit. 2, §§ 60100, subd. (e), 60110, subd. (c)(2).) Under prior law, the expanded IEP team identified the placement. (Former Cal. Code Regs., tit. 2, § 60100, subd. (f).)
- Document the determination that no nearby placement alternative that is able to implement the IEP can be identified and seek an appropriate placement that is as close to the parents' home as possible. (Cal. Code Regs., tit. 2, § 60100, subd. (f).)
- Notify the local educational agency that the placement has been arranged and coordinate the transportation of the pupil to the facility if needed. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(7).)
- Facilitate placement authorization from the county's interagency placement committee pursuant to Welfare and Institutions Code section 4094.5, subdivision (e)(1), by presenting the case of a pupil with a disability who is seriously emotionally disturbed prior to placement in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(11).)[61]

The Commission finds that the new activities bulleted above constitute a new program or higher level of service.

In addition, the language for some of the case management activities required under existing law was amended by section 60110 of the test claim legislation. Thus, the issue is whether the amended language mandates an increase in the level of service provided by the county case manager.

For example, existing law required counties to "conven[e] parents and representatives of public and private agencies in accordance with subsection (f) of Section 60100 in order to identify the appropriate residential placement." (Former Cal. Code Regs., tit. 2, § 60110,

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[60] A "community treatment facility" is defined in section 60025 of the regulations to mean "any residential facility that provides mental health treatment services to children in a group setting which has the capacity to provide secure confinement. The facility's program components shall be subject to program standards developed and enforced by the State Department of Mental Health pursuant to Section 4094 of the Welfare and Institutions Code."

[61] Welfare and Institutions Code section 4094.5, subdivision (e)(1), states in relevant part that "[t]he child shall, prior to admission, have been determined to be in need of the level of care provided by a community treatment facility, by a county interagency placement committee …"

subd. (c)(1).) Section 60110, subdivision (c)(1), as replaced by the test claim legislation, amended the regulation, in relevant part, by requiring the county case manager to include "educational staff" in the meeting. The Commission finds that the requirement to include "educational staff" in the meeting does not increase the level of service required by county case managers. The old regulation required county case managers to convene the meeting with "representatives of public agencies." For purposes of this program, "representatives of public agencies" includes educational staff.[62] Thus, section 60110, subdivision (c)(1), does not impose a new program or higher level of service.

Furthermore, former section 60110, subdivision (c)(8), required case managers to conduct quarterly face-to-face contacts with the pupil at the residential facility to monitor the level of care and supervision and the implementation of the treatment services as required by the IEP. That requirement remains the law. However, section 60110, subdivision (c)(8), as replaced by the test claim legislation, requires the case manager to also evaluate "the continuing stay criteria" of a pupil placed in a community treatment facility on a quarterly basis:

> In addition, for children placed in a community treatment facility, an evaluation shall be made within every 90 days of the residential placement of the pupil to determine if the pupil meets the continuing stay criteria as defined in Welfare and Institutions Code section 4094 and implementing mental health regulations.

Pursuant to Department of Mental Health regulations, the continuing stay criteria require the case manager and the community treatment facility psychiatrist to evaluate and document the continued placement of the pupil in the community treatment facility.[63]

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[62] See section 60000 of the regulations, which provides that "this chapter applies to the State Departments of Mental Health, Social Services, and their designated local agencies, and the California Department of Education, school districts, county offices, and special education local plan areas."

[63] California Code of Regulations, title 9, section 1924, defines the "continuing stay criteria" for this program as follows:

> (b) Individuals who are special education pupils identified in paragraph (4) of subdivision (c) of Section 56026 of the Education Code and who are placed in a CTF [community treatment facility] prior to age eighteen (18) pursuant to Chapter 26.5 of the Government Code may continue to receive services through age 21 provided the following conditions are met:
>
> (1) They continue to satisfy the requirements of subsection (a) [documentation by the CTF psychiatrist and the case manager supporting the continued placement of the pupil in the community treatment facility];
>
> (2) They have not graduated from high school;
>
> (3) They sign a consent for treatment and a release of information for CTF staff to communicate with education and county mental health

The Commission finds that the evaluation every 90 days of the continuing stay criteria of a pupil placed in a community treatment facility, as required by section 60110, subdivision (c)(8), constitutes a new program or higher level of service.

Finally, under prior law, the expanded IEP team was required to review the case progress, the continuing need for out-of-home placement, the extent of compliance with the IEP, and progress toward alleviating the need for out-of-home care "at least every six months." (Gov. Code, § 7572.5, subd. (c)(2).) In addition, former section 60110, subdivision (c)(10), required case managers to "coordinate the six-month expanded IEP team meeting with the local educational agency administrator or designee."

Section 60110, subdivision (c)(10), as adopted by the test claim legislation in 1998, replaced the requirement imposed on the case manager to "coordinate" the expanded six-month IEP team meeting, with the requirement to "schedule and attend" the six-month expanded IEP team meeting. Section 60110, subdivision (c)(10), states the following:

> Schedule and attend the next expanded IEP team meeting with the expanded IEP team's administrative designee within six months of the residential placement of a pupil with a disability who is seriously emotionally disturbed and every six months thereafter as the pupil remains in residential placement.

The Commission finds that section 60110, subdivision (c)(10), increases the level of service required of counties. Under the prior requirement, case managers were required to coordinate the expanded IEP team meeting every six months. Case managers are now required to schedule the meeting. The activities of "coordinating" and "scheduling" are different. To "coordinate" means to "to place in the same order, class, or rank; to harmonize in a common effort; to work together harmoniously." To "schedule" means "to plan or appoint for a certain date or time."[64] In addition, although a representative from the county is a member of the IEP team, there was no requirement that the case manager, who may be a different person than the IEP team member, attend the IEP team meeting.[65] Therefore, the Commission finds that section 60110, subdivision (c)(10), of the regulations constitutes a new program or higher level of service for the activity of scheduling and attending the six-month expanded IEP team meetings.

> professionals after staff have informed them of their rights as an adult;
>
> (4) A CTF obtains an exception from the California Department of Social Services to allow for the continued treatment of the young adult in a CTF… .

[64] Webster's II New College Dictionary (1999) pages 248, 987.

[65] Existing law authorizes the county to delegate the case management responsibilities to the county welfare department. (Gov. Code, § 7572.5, subd. (c)(1).)

F. Authorize Payments to Out-Of-Home Residential Care Providers (Cal. Code Regs., tit. 2, § 60200, subd. (e))

Pursuant to existing law, counties are financially responsible for 60 percent of the total residential and non-educational costs of a seriously emotionally disturbed pupil placed in an out-of-home residential facility. The residential and non-educational costs include the costs for food, clothing, shelter, daily supervision, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation. (Gov. Code, § 7581, former Cal. Code Regs., tit. 2, § 60200, subd. (e), Welf. & Inst. Code, § 15200, subd. (c)(1).) The counties' financial responsibility for the residential and non-educational costs of pupils placed out of the home remain the law today.

In addition, former section 60200 of the regulations required the county welfare department to issue the payments to providers of out-of-home facilities in accordance with Welfare and Institutions Code section 18351, upon receipt of authorization documents from the State Department of Mental Health *or* a designated county mental health agency. The authorization documents are required to include information sufficient to demonstrate that the child meets all eligibility criteria established in the regulations for this program. (Welf. & Inst. Code, § 18351.)

The county welfare department is still required to issue payments to the residential facilities under section 60200, subdivision (e), of the regulations, as replaced in 1998. However, the regulation now requires the county community mental health service to authorize the payment to the residential facility before the county welfare agency can issue the payment. Subdivision (e) states, "[t]he community mental health service shall be responsible for authorizing payment to the facilities listed in Section 60025 based upon rates established by the Department of Social Services in accordance with Sections 18350 through 18356 of the Welfare and Institutions Code."

The Department of Finance contends that "[a]ccording to the Department of Social Services, there is no meaningful difference between the requirements under the prior regulations and the new regulations with respect to authorizing payments to the out-of-home residential facilities." The Department further states that "the child's mental health caseworker is already required to participate in the development of the IEP, and this IEP could constitute the authorizing paperwork that is presented to the county child welfare department to initiate payment for residential treatment." Thus, the Department argues that "[i]t is not clear that the new requirement . . . would impose a new or higher level of service."[66]

The Commission disagrees with the Department's interpretation of section 60200 of the regulations. The same rules of construction applicable to statutes govern the interpretation of administrative regulations. Thus, the Commission, like a court, should attempt to ascertain the intent of the regulating agency.[67]

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[66] Department of Finance comments to the draft staff analysis.

[67] *Goleta Valley Community Hospital v. Department of Health Services* (1984) 149 Cal.App.3d 1124, 1129.

As indicated above, prior law specified that either the Department of Mental Health or a designated county mental health agency provided the authorization documents before payment to the residential facility could be issued. According to the final statement of reasons prepared by the Departments of Mental Health and Education for the 1998 regulations, section 60200, subdivision (e), now assigns the responsibility of authorizing payments to the residential facilities solely to the county community mental health service. The final statement of reasons also states that it is the responsibility of the county to determine that the residential placement meets all of the criteria established in Welfare and Institutions Code sections 18350 through 18356. The final statement of reasons for this regulation expressly provides the following:

> Subsection (e) assigns the responsibility for authorizing payment for board and care to the community mental health service. It is the responsibility of the community mental health service to determine that the residential placement meets all of the criteria established in Sections 18350 through 18356 of the Welfare and Institutions Code. These sections of code also refer to Section 11460 of the Welfare and Institutions Code which state that rates will be established by CDSS, and outline certain requirements in order for facilities to be eligible for payment."[68]

Thus, compliance with section 60200, subdivision (e), of the regulations requires the counties to determine that the residential placement meets all of the criteria established in the Welfare and Institutions Code before authorizing payment. The final statement of reasons suggests that the requirement to authorize payment to residential facilities may not be satisfied by simply providing the IEP to the county welfare department.

The Department of Social Services has not provided the Commission with any comments on this test claim. In addition, the argument asserted by the Department of Finance is not supported with documentary evidence or declarations signed under the penalty of perjury, as required by the Commission's regulations. (Cal. Code Regs., tit. 2, § 1183.02, subd. (c).)

Accordingly, the Commission finds that authorizing payments to the residential facilities in accordance with section 60200, subdivision (e), constitutes a new program or higher level of service.

G. Provide Psychotherapy or Other Mental Health Treatment Services (Cal. Code Regs, tit. 2, §§ 60020, subd. (i), 60050, subd. (b), 60200, subd. (c))

Pursuant to existing law, counties are required to provide psychotherapy or other mental health treatment services to a pupil, either directly or by contract, when required by the pupil's IEP. (Gov. Code, § 7576; former Cal. Code Regs., tit. 2, § 60200, subd. (b).) Under the former regulations, "psychotherapy and other mental health services" were defined to include the day services and outpatient services identified in sections 542 and 543 of the Department of Mental Health regulations. (Former Cal. Code Regs., tit. 2, § 60020, subd. (a).)

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[68] Final Statement of Reasons, page 26.

The regulations adopted by the Departments of Education and Mental Health in 1998 modified these activities. For example, section 60200, subdivision (c)(1), adds new requirements when a pupil receives mental health services in a host county. Under such circumstances, the county of origin (the county where the parent resides, the pupil receives adoption assistance, or where the pupil is a ward of the court, for example) is financially responsible for the mental health services, even though the services are provided in a host county. (Cal. Code Regs., tit. 2, § 60200, subd. (c).) Section 60200, subdivision (c)(1), states the following:

> The host county shall be responsible for making its provider network available and shall provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. Counties of origin shall negotiate with host counties to obtain access to limited resources, such as intensive day treatment and day rehabilitation.

Thus, the Commission finds that section 60200, subdivision (c)(1), of the regulations mandates a new program or higher level of service for the following new activities:

- The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals.
- The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation.

In addition, section 60020, subdivision (i), changed the definition of mental health services. As indicated above, the former regulations defined "psychotherapy and other mental health services" to include the day services and outpatient services identified in sections 542 and 543 of the Department of Mental Health regulations. (Former Cal. Code Regs., tit. 2, § 60020, subd. (a).) Under the prior regulations, these services included the following: day care intensive services, day care habilitative (counseling and rehabilitative) services, vocational services, socialization services, collateral services, assessment, individual therapy, group therapy, medication (including the prescribing, administration, or dispensing of medications, and the evaluation of side effects and results of the medication), and crisis intervention.

Section 60020, subdivision (i), of the regulations, now defines "mental health services" as follows:

> "Mental health services" means mental health assessment and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code: psychotherapy as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management. These services shall be provided directly or by contract at the discretion of the community mental health service of the county of origin.

Section 60020 of the test claim regulations continues to include mental health assessments, collateral services, intensive day treatment, and day rehabilitation within the definition of "mental health services." These services are not new.[69]

However, the activities of crisis intervention, vocational services, and socialization services were deleted by the test claim regulations. The final statement of reasons, in responding to a comment that these activities remain in the definition of "mental health services," states the following:

> The provision of vocational services is assigned to the State Department of Rehabilitation by Government Code section 7577.
>
> Crisis service provision is delegated to be "from other public programs or private providers, as appropriate" by these proposed regulations in Section 60040(e) because crisis services are a medical as opposed to educational service. They are, therefore, excluded under both the Tatro and Clovis decisions. These precedents apply because "medical" specialists must deliver the services. A mental health crisis team involves specialized professionals. Because of the cost of these professional services, providing these services would be a financial burden that neither the schools nor the local mental health services are intended to address in this program.
>
> The hospital costs of crisis service provision are explicitly excluded from this program in the Clovis decision for the same reasons.
>
> Additionally, the IEP process is one that responds slowly due to the problems inherent in convening the team. It is, therefore, a poor avenue for the provision of crisis services. While the need for crisis services can be a predictable requirement over time, the particular medical requirements of the service are better delivered through the usual local mechanisms established specifically for this purpose.[70]

Thus, counties are not eligible for reimbursement for providing crisis intervention, vocational services, and socialization services since these activities were repealed as of July 1, 1998.

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[69] The County of Los Angeles, in comments to the draft staff analysis, argues that all activities specified in section 60020, subdivision (i), should be reimbursable under this test claim. The County of Stanislaus filed similar comments. As indicated in the analysis, however, the activities of mental health assessments, collateral services, intensive day treatment, and case management, are not new activities. Counties were required to perform these activities under the prior regulations. (Former Cal. Code Regs., tit. 2, § 60020, subd. (a).) Reimbursement for the activities of mental health assessments, collateral services, intensive day treatment, and case management, are addressed in the reconsideration of the original *Handicapped and Disabled Students* program (04-RL-4282-10).

[70] Final Statement of Reasons, pages 55-56.

Nevertheless, section 60020 of the regulations increases the level of service of counties providing mental health services by including case management services and "psychotherapy" within the meaning of "mental health services." The regulation defines psychotherapy to include both individual and group therapy, based on the definition in Business and Professions Code section 2903. Business and Professions Code section 2903 states in relevant part the following:

> No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter, except as otherwise provided in this chapter. The practice of psychology is defined as rendering or offering to render for a fee to individuals, groups, organizations or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations.
>
> The application of these principles and methods includes, but is not restricted to: diagnosis, prevention, treatment, and amelioration of psychological problems and emotional and mental disorders of individuals and groups.
>
> Psychotherapy within the meaning of this chapter means the use of psychological methods in a professional relationship to assist a person or persons to acquire greater human effectiveness or to modify feelings, conditions, attitudes and behavior which are emotionally, intellectually, or socially ineffectual or maladjustive.

The Commission finds that providing the services of case management and psychotherapy, as defined in Business and Professions Code section 2903, to a pupil when required by the pupil's IEP constitutes a new program or higher level of service.

Furthermore, under prior law, mental health services included prescribing, administering, and dispensing medications, and evaluating the side effects and results of the medication. Section 60020, subdivision (i), now includes "medication monitoring" within the provision of mental health services. "Medication monitoring" is defined in section 60020, subdivision (f), as follows:

> "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness.

The Department of Finance argues that "medication monitoring" does not increase the level of service provided by counties. The Department states the following:

> It is our interpretation that there is no meaningful difference between the medication requirements under the prior regulations and the new regulations of the test claim. The existing activities of "dispensing of medications, and the evaluation of side effects and results of medication" are in fact activities of medication monitoring and seem representative of all aspects of medication monitoring. To the extent that counties are already required to evaluate the "side effects and results of medication," it is not clear that the new requirement of "medication monitoring" imposes a new or higher level of service.[71]

The Commission disagrees with the Department's interpretation of section 60020, subdivisions (i) and (f), of the regulations, and finds that "medication monitoring" as defined in the regulation increases the level of service required of counties.

The same rules of construction applicable to statutes govern the interpretation of administrative regulations.[72] Under the rules of statutory construction, it is presumed that the Legislature or the administrative agency intends to change the meaning of a law or regulation when it materially alters the language used.[73] The courts will not infer that the intent was only to clarify the law when a statute or regulation is amended unless the nature of the amendment clearly demonstrates the case.[74]

In the present case, the test claim regulations, as replaced in 1998, materially altered the language regarding the provision of medication. The activity of "dispensing" medications was deleted from the definition of mental health services. In addition, the test claim regulations deleted the phrase "evaluating the side effects and results of the medication," and replaced the phrase with "monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness." The definitions of "evaluating" and "monitoring" are different. To "evaluate" means to "to examine carefully; appraise."[75] To "monitor" means to "to keep watch over; supervise."[76] The definition of "monitor" and the regulatory language to monitor the "psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness" indicate that the activity of "monitoring" is an ongoing activity necessary to ensure that the pupil receives a free and appropriate education under federal law. This interpretation is supported by the final statement of reasons for the adoption of the language in section 60020, subdivision (f), which state that the regulation was intended to make it

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[71] Department of Finance comments to draft staff analysis.

[72] *Goleta Valley Community Hospital v. Department of Health Services* (1984) 149 Cal.App.3d 1124, 1129.

[73] *Garrett v. Young* (2003) 109 Cal.App.4th 1393, 1404-1405.

[74] *Medina v. Board of Retirement, Los Angeles County Employees Retirement Assn.* (2003) 112 Cal.App.4th 864, 869-870.

[75] Webster's II New College Dictionary (1999) page 388.

[76] *Id.* at page 708.

clear that "medication monitoring" is an educational service that is provided pursuant to an IEP, rather than a medical service that is not allowable under the program.[77]

Neither the Department of Mental Health nor the Department of Education, agencies that adopted the regulations, filed substantive comments on this test claim. Thus, there is no evidence in the record to contradict the finding, based on the rules of statutory construction, that "medication monitoring" increases the level of service on counties.

Therefore, the Commission finds that the activity of "medication monitoring," as defined in section 60020, subdivisions (f) and (i), constitutes a new program or higher level of service.

Finally, section 60050 was added by the test claim legislation to address the completion or termination of IEP health services. In relevant part, section 60050, subdivision (b), states the following:

> When completion or termination of IEP specified health services is mutually agreed upon by the parent and the community mental health service, or when the pupil is no longer participating in treatment, the community mental health service shall notify the parent and the LEA which shall schedule an IEP meeting to discuss and document this proposed change it if is acceptable to the IEP team.

The Commission finds that section 60050, subdivision (b), mandates a new program or higher level of service by requiring counties to notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of the service, or when the pupil is no longer participating in treatment.

H. Participation in Due Process Hearings (Cal. Code Regs., tit. 2, § 60550)

The County of Los Angeles argues that a county's participation in a due process hearing, which resolves disputes between a parent and a public agency regarding special education and related services, is reimbursable. The County further argues that reimbursement should cover the costs for "participation in mediation conferences, travel costs associated with dispute resolution, preparation of witnesses and documentary evidence, as well as participation in administrative hearings …"[78] The Commission disagrees.

Under existing law, due process procedures are in place to resolve disputes between a parent and a public agency regarding the special education and related services, including mental health services provided to a pupil by a county under the Handicapped and Disabled Students program. Government Code section 7586, as originally enacted in 1984, requires all state departments and their designated local agencies, including counties, to be governed by the procedural due process protections required by federal law. Government Code section 7586, subdivision (a), states the following:

> All state departments, and their designated local agencies, shall be governed by the procedural safeguards required in Section 1415 of

[77] Final Statement of Reasons, page 7.

[78] County of Los Angeles' comments to the draft staff analysis.

> Title 20 of the United States Code. A due process hearing arising over a related service or designated instruction and service shall be filed with the Superintendent of Public Instruction. Resolution of all issues shall be through the due process hearing process established in Chapter 5 (commencing with Section 56500) of Part 30 of Division 4 of the Education Code. The decision issued in the due process hearing shall be binding on the department having responsibility for the services in issue as prescribed by this chapter.

Pursuant to the former regulations, counties were required to participate in the due process hearings relating to issues involving mental health assessments or services and were required to prepare documentation and provide testimony supporting the county's position. (Former Cal. Code Regs., tit. 2, § 60550.) Counties are currently eligible for reimbursement for their participation in the due process hearings.

The test claim legislation, section 60550 of the regulations, as enacted in 1998, does not increase the level of service provided by counties with respect to the due process hearings. Counties are still subject to the due process hearing procedures as they were under prior law, and are still required to prepare documentation and provide testimony to support its position. According to the final statement of reasons, the amendments in the regulation, with respect to the county, simply reflect the deletion of the Office of Administrative Hearings from the hearing process.

Therefore, the Commission finds that section 60550 does not mandate that counties perform new activities or increase their level of service. Therefore, section 60550 of the regulations does not impose a new program or higher level of service on counties.

I. Compliance Complaints (Cal. Code Regs., tit. 2, § 60560)

The County of Stanislaus requests reimbursement for defending against an allegation that the county has not complied with the regulations for this program, in accordance with section 60560 of the regulations. Section 60560 states that "[a]llegations of failure by an LEA, Community Mental Health Services or CCS to comply with these regulations, shall be resolved pursuant to [sections 4600 et seq. of the Department of Education regulations]."

The Commission finds that the compliance complaint procedure established by section 60560 does not constitute a new program or higher level of service. The compliance complaint procedures, as they relate to the counties' participation in the Handicapped and Disabled Students program, have been in the law since 1991. Section 4650 of the Department of Education regulations (the regulation cited as the authority for section 60560 of the joint regulations in this case) addresses compliance complaints and was adopted in 1991.[79] Section 4650, subdivision (a)(viii), states in relevant part the following:

> For complaints relating to special education the following shall also be conditions for direct state intervention:

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[79] California Code of Regulations, title 5, section 4650.

> (A) The complainant alleges that a public agency, other than a local educational agency, as specified in Government Code section 7570 et seq., fails or refuses to comply with an applicable law or regulation relating to the provision of free appropriate public education to handicapped individuals …

Therefore, the Commission finds that section 60560 does not constitute a new program or higher level of service.

J. Interagency Dispute Resolution (Cal. Code Regs., tit. 2, §§ 60600, 60610)

The County of Stanislaus requests reimbursement for the counties' participation in interagency dispute resolution procedures, in accordance with sections 60600 and 60610 of the regulations. These regulations implement Government Code section 7585, which was enacted in 1984. Government Code section 7585 provides that whenever any department or local agency designated by that department fails to provide a related service specified in a pupil's IEP, the parent, adult pupil, or any local educational agency shall submit a written notification of the failure to provide the service to the Superintendent of Public Instruction or the Secretary of Health and Welfare. The superintendent and the secretary, or their designees, shall meet to resolve the issue within 15 days. If the issue cannot be resolved, the matter is referred to the Office of Administrative Hearings, whose decision is binding on the parties. Under prior regulations (former section 60610), once the dispute resolution procedures have been completed, the agency determined responsible for the service shall pay for, or provide the service, and shall reimburse the other agency that provided the service, if applicable.

Sections 60600 and 60610, as adopted in 1998, do not change the prior dispute resolution procedures. The level of participation by the county under the interagency dispute resolution procedures remains the same.

Therefore, the Commission finds that sections 60600 and 60610 of the regulations do not mandate a new program or higher level of service on counties.

Issue 4: Do the test claim statutes and regulations impose costs mandated by the state within the meaning of article XIII B, section 6 and Government Code section 17514?

As indicated above, the Commission finds that the following activities mandate a new program or higher level of service on counties:

1. Interagency Agreements (Cal. Code Regs., tit. 2, § 60030)
    - The one-time activity of revising the interagency agreement with each local educational agency to include the following eight procedures:
        - Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code section 7575, subdivision (f). For purposes of this subdivision only, the term "appropriate" means any service identified in the pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(2).)

- o A host county to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)
- o Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)
- o At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)
- o The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)
- o The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)
- o The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)
- o Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)

2. Referral and Mental Health Assessments (Gov. Code, § 7576; Cal. Code Regs., tit. 2, §§ 60040, 60045)

- Work collaboratively with the local educational agency to ensure that assessments performed prior to referral are as useful as possible to the community mental health service in determining the need for mental health services and the level of services needed. (Gov. Code, § 7576, subd. (b)(1).)
- A county that receives a referral for a pupil with a different county of origin shall forward the referral within one working day to the county of origin. (Gov. Code, § 7576, subd. (g); Cal. Code Regs., tit. 2, § 60040, subd. (g).)
- If the county determines that a mental health assessment is not necessary, the county shall document the reasons and notify the parents and the local educational agency of the county determination within one day. (Cal Code Regs., tit. 2, § 60045, subd. (a)(1).)

- If the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral. (Cal. Code Regs., tit. 2, § 60045, subd. (a)(2).)
- Notify the local educational agency when an assessment is determined necessary. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)
- Provide the assessment plan to the parent. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)
- Report back to the referring local educational agency or IEP team within 30 days from the date of the receipt of the referral if no parental consent for a mental health assessment has been obtained. (Cal. Code Regs., tit. 2, § 60045, subd. (c).)
- Notify the local educational agency within one working day after receipt of the parent's written consent for the mental health assessment to establish the date of the IEP meeting. (Cal. Code Regs., tit. 2, § 60045, subd. (d).)
- Provide the parent with written notification that the parent may require the assessor to attend the IEP meeting to discuss the recommendation when the parent disagrees with the assessor's mental health service recommendation. (Cal. Code Regs., tit. 2, § 60045, subd. (f).)
- The county of origin shall prepare yearly IEP reassessments to determine the needs of a pupil. (Cal. Code Regs., tit. 2, § 60045, subd. (h).)

3. Transfers and Interim Placements (Cal. Code Regs., tit. 2, § 60055)
   - Following a pupil's transfer to a new school district, the county shall provide interim mental health services, as specified in the existing IEP, for thirty days, unless the parent agrees otherwise.
   - Participate as a member of the IEP team of a transfer pupil to review the interim services and make a determination of services.
4. Participate as a Member of the Expanded IEP Team When Residential Placement of a Pupil is Recommended (Gov. Code, § 7572.55; Cal Code Regs., tit. 2, § 60100)
   - When a recommendation is made that a child be placed in an out-of-state residential facility, the expanded IEP team, with the county as a participant, shall develop a plan for using less restrictive alternatives and in-state alternatives as soon as they become available, unless it is in the best educational interest of the child to remain in the out-of-state school. (Gov. Code, § 7572.55, subd. (c).)
   - The expanded IEP team, with the county as a participant, shall document the alternatives to residential placement that were considered and the reasons why they were rejected. (Cal. Code Regs., tit. 2, § 60100, subd. (c).)

- The expanded IEP team, with the county as a participant, shall ensure that placement is in accordance with the admission criteria of the facility. (Cal. Code Regs., tit. 2, § 60100, subd. (j).)
- When the expanded IEP team determines that it is necessary to place a pupil who is seriously emotionally disturbed in residential care, counties shall ensure that: (1) the mental health services are specified in the IEP in accordance with federal law, and (2) the mental health services are provided by qualified mental health professionals. (Cal. Code Regs., tit. 2, § 60100, subd. (i).)

5. Case Management Duties for Pupils Placed in Residential Care (Cal. Code Regs., tit. 2, §§ 60100, 60110)
   - Coordinate the residential placement plan of a pupil with a disability who is seriously emotionally disturbed as soon as possible after the decision has been made to place the pupil in residential placement. The residential placement plan shall include provisions, as determined in the pupil's IEP, for the care, supervision, mental health treatment, psychotropic medication monitoring, if required, and education of the pupil. (Cal. Code Regs., tit, 2, § 60110, subd, (b)(1).)
   - When the IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a community treatment facility, the lead case manager shall ensure that placement is in accordance with admission, continuing stay, and discharge criteria of the community treatment facility. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(3).)
   - Identify, in consultation with the IEP team's administrative designee, a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost-effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment. (Cal. Code Regs, tit. 2, §§ 60100, subd. (e), 60110, subd. (c)(2).)
   - Document the determination that no nearby placement alternative that is able to implement the IEP can be identified and seek an appropriate placement that is as close to the parents' home as possible. (Cal. Code Regs., tit. 2, § 60100, subd. (f).)
   - Notify the local educational agency that the placement has been arranged and coordinate the transportation of the pupil to the facility if needed. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(7).)
   - Facilitate placement authorization from the county's interagency placement committee pursuant to Welfare and Institutions Code section 4094.5, subdivision (e)(1), by presenting the case of a pupil with a disability who is seriously emotionally disturbed prior to placement in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(11).)

- Evaluate every 90 days the continuing stay criteria, as defined in Welfare and Institutions Code section 4094, of a pupil placed in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(8).)
- Schedule and attend the next expanded IEP team meeting with the expanded IEP team's administrative designee within six months of the residential placement of a pupil with a disability who is seriously emotionally disturbed and every six months thereafter as the pupil remains in residential placement. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(10).)

6. Authorize Payments to Out-Of-Home Residential Care Providers (Cal. Code Regs., tit. 2, § 60200, subd. (e))

   - Authorize payments to residential facilities based on rates established by the Department of Social Services in accordance with Welfare and Institutions Code sections 18350 and 18356.

7. Provide Psychotherapy or Other Mental Health Treatment Services (Cal. Code Regs., tit. 2, §§ 60020, subd. (i), 60050, subd. (b), 60200, subd. (c))

   - The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)
   - The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)
   - Provide case management services to a pupil when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
   - Provide individual or group psychotherapy services, as defined in Business and Professions Code section 2903, when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
   - Provide medication monitoring services when required by the pupil's IEP. "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subds. (f) and (i).)
   - Notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of a service, or when the pupil is no longer participating in treatment. ((Cal. Code Regs., tit. 2, § 60050, subd. (b).)

In order for the activities listed above to impose a reimbursable, state-mandated program under article XIII B, section 6 of the California Constitution, two additional elements must be satisfied. First, the activities must impose costs mandated by the state pursuant to Government Code section 17514.[80] Second, the statutory exceptions to reimbursement listed in Government Code section 17556 cannot apply.

Government Code section 17514 defines "costs mandated by the state" as any increased cost a local agency or school district is required to incur as a result of a statute that mandates a new program or higher level of service.

Government Code section 17556 states that the Commission shall not find costs mandated by the state, as defined in section 17514, in any claim submitted by a local agency or school district, if, after a hearing, the commission finds that:

> (a) The claim is submitted by a local agency or school district that requested legislative authority for that local agency or school district to implement the program specified in the statute, and that statute imposes costs upon that local agency or school district requesting the legislative authority. A resolution from the governing body or a letter from a delegated representative of the governing body of a local agency or school district that requests authorization for that local agency or school district to implement a given program shall constitute a request within the meaning of this paragraph.
>
> (b) The statute or executive order affirmed for the state a mandate that had been declared existing law or regulation by action of the courts.
>
> (c) The statute or executive order imposes a requirement that is mandated by a federal law or regulation and results in costs mandated by the federal government, unless the statute or executive order mandates costs that exceed the mandate in that federal law or regulation. This subdivision applies regardless of whether the federal law or regulation was enacted or adopted prior to or after the date on which the state statute or executive order was enacted or issued.
>
> (d) The local agency or school district has the authority to levy service charges, fees, or assessments sufficient to pay for the mandated program or increased level of service.
>
> (e) The statute, executive order, or an appropriation in a Budget Act or other bill provides for offsetting savings to local agencies or school districts that result in no net costs to the local agencies or school districts, or includes additional revenue that was specifically intended to fund the costs of the state mandate in an amount sufficient to fund the cost of the state mandate.
>
> (f) The statute or executive order imposed duties that were expressly included in a ballot measure approved by the voters in a statewide or local election.

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[80] See also, *Lucia Mar Unified School Dist.*, *supra*, 44 Cal.3d 830, 835.

> (g) The statute created a new crime or infraction, eliminated a crime or infraction, or changed the penalty for a crime or infraction, but only for that portion of the statute relating directly to the enforcement of the crime or infraction.

Except for Government Code section 17556, subdivision (e), the Commission finds that the exceptions listed in section 17556 are not relevant to this claim, and do not apply here. Since the Legislature has appropriated funds for this program, however, Government Code section 17556, subdivision (e), is relevant and is analyzed below.

A. Government Code section 17556, subdivision (e), does not apply to deny this claim

Government Code section 17556, subdivision (e), states the Commission shall not find costs mandated by the state if the Commission finds that:

> The statute, executive order, or an appropriation in a Budget Act or other bill provides for offsetting savings to local agencies or school districts that result in no net costs to the local agencies or school districts, *or includes additional revenue that was specifically intended to fund the costs of the state mandate in an amount sufficient to fund the cost of the state mandate*. (Emphasis added.)

Thus, in order for Government Code section 17556, subdivision (e), to apply to deny this claim, the plain language of the statute requires that two elements be satisfied. First, the statute must include additional revenue that was specifically intended to fund the costs of the state mandate. Second, the appropriation must be in an amount sufficient to fund the cost of the state mandate.

For the reasons provided below, the Commission finds that Government Code section 17556, subdivision (e), does not apply to deny this claim.

The reimbursement period of this test claim, if approved by the Commission, would begin July 1, 2001. The Budget Act of 2001 appropriated funds to counties specifically for this program in the amounts of $12,334,000 and $46,944,000.[81] The Budget Act of 2002 appropriated $1000 to counties.[82]

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[81] Statutes 2001, chapter 106, items 4440-131-0001 and 4440-295-0001. Item 4440-295-0001, however, is an appropriation, pursuant to article XIII B, section 6, for the original program approved by the Commission in CSM 4282, *Handicapped and Disabled Students* (Stats. 1984, ch. 1747; Stats. 1985, ch. 1274; and on Cal. Code Regs., tit.2, §§ 60000 through 60610 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)).

[82] Statutes 2002, chapter 379, item 4440-295-0001. Item 4440-295-0001 is an appropriation, pursuant to article XIII B, section 6, for the original program added approved by the Commission in CSM 4282, *Handicapped and Disabled Students* (Stats. 1984, ch. 1747; Stats. 1985, ch. 1274; and on Cal. Code Regs., tit.2, §§ 60000 through 60610 (Emergency Regulations filed December 31, 1985, designated effective January 1,

The Commission finds that the amount appropriated in 2001 and 2002 are not sufficient to fund the cost of the state mandate and, thus, the second element under Government Code section 17556, subdivision (e), has not been satisfied. According to the State Controller's Deficiency Report issued on May 2, 2005, the unpaid claims for fiscal year 2001-02 total $124,940,258. The unpaid claims for fiscal year 2002-03 total $124,871,698.[83]

In addition, the Budget Acts of 2003 and 2004 contain appropriations "considered offsetting revenues within the meaning of Government Code section 17556, subdivision (e)." However, for the reasons provided below, the Commission finds that Government Code section 17556, subdivision (e), has not been satisfied with these appropriations.

The Budget Act of 2003 appropriated $69 million to counties from the federal special education fund to be used exclusively to support mental health services identified in a pupil's IEP and provided during the 2003-04 fiscal year by county mental health agencies pursuant to the test claim legislation. (Stats. 2003, ch. 157, item 6110-161-0890, provision 17.) The bill further states in relevant part that the funding shall be considered offsetting revenue pursuant to Government Code section 17556, subdivision (e):

> This funding shall be considered offsetting revenues within the meaning of subdivision (e) of section 17556 of the Government Code for any reimbursable mandated cost claim for provision of these mental health services provided in 2003-04.

The Budget Act of 2004 similarly appropriated $69 million to counties from the federal special education fund to be used exclusively to support mental health services provided during the 2004-05 fiscal year pursuant to the test claim legislation. (Stats. 2004, ch. 208, item 6110-161-0890, provision 10.) The appropriation in 2004 was made as follows:

> Pursuant to legislation enacted in the 2003-04 Regular Session, of the funds appropriated in Schedule (4) of this item, $69,000,000 shall be used exclusively to support mental health services provided during the

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1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)).

[83] The Deficiency Report is prepared pursuant to Government Code section 17567. Government Code section 17567 requires that in the event the amount appropriated for reimbursement of a state-mandated program is not sufficient to pay all of the claims approved by the Controller, the Controller shall prorate claims in proportion to the dollar amount of approved claims timely filed and on hand at the time of proration. The Controller shall then issue a report of the action to the Department of Finance, the Chairperson of the Joint Legislative Budget Committee, and the Chairperson of the respective committee in each house of the Legislature that considers appropriations. The Deficiency Report is, thus, an official record of a state agency and is properly subject to judicial notice by the court. (*Munoz v. State* (1995) 33 Cal.App.4th 1767, 1773, fn. 2; *Chas L. Harney, Inc. v. State of California* (1963) 217 Cal.App.2d 77, 85-87.)

> 2004-05 fiscal year by county mental health agencies pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of the Government Code and that are included within an individualized education program pursuant to the Federal Individuals with Disabilities Education Act (IDEA).

The Budget Act of 2004 does not expressly identify the $69 million as "offsetting revenues within the meaning of Government Code section 17556, subdivision (e)." But the statute does contain language that the appropriation was made "[p]ursuant to legislation enacted in the 2003-04 Regular Session." As indicated above, it is the 2003-04 Budget Bill that contains the language regarding the Legislature's intent that the $69 million is considered offsetting revenue within the meaning of Government Code section 17556, subdivision (e).

The Commission finds that the Legislature intended to fund the costs of this state-mandated program for fiscal year 2004-05 based on the language used by the Legislature that the funds "shall be considered offsetting revenues within the meaning of Government Code section 17556, subdivision (e)." Under the rules of statutory construction, it is presumed that the Legislature is aware of existing laws and that it enacts new laws in light of the existing law.[84] In this case, the Legislature specifically referred to Government Code section 17556, subdivision (e), when appropriating the $69 million. Thus, it must be presumed that the Legislature was aware of the plain language of Government Code section 17556, subdivision (e), and that its application results in a denial of a test claim.

But, based on public records, the second element under Government Code section 17556, subdivision (e), requiring that the appropriation must be *in an amount sufficient* to fund the cost of the state mandate, has not been satisfied. According to the State Controller's Deficiency Report issued on May 2, 2005, the amounts appropriated for this program in fiscal years 2003-04 and 2004-05 are not sufficient to pay the claims approved by the State Controller's Office. Unpaid claims for fiscal year 2003-04 total $66,915,606. The unpaid claims for fiscal year 2004-05 total $68,958,263.[85]

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[84] *Williams v. Superior Court* (2001) 92 Cal.App.4th 612, 624.

[85] The State Controller's Deficiency Report lists the total unpaid claims for the following fiscal years as follows:

1999 and prior Local Government Claims Bills	$ 8,646
2001-02	124,940,258
2002-03	124,871,698
2003-04	66,915,606
2004-05	68,958,263

This finding is further supported by the 2004 report published by Stanford Law School, which states "$69 million represented only approximately half of the total funding necessary to maintain AB 3632 services."[86]

Accordingly, the Commission finds that Government Code section 17556, subdivision (e), does not apply to deny this claim. Eligible claimants are, however, required to identify the funds received during fiscal years 2001-02 through 2004-05 as an offset to be deducted from the costs claimed.[87]

Based on the program costs identified by the State Controller's Office, the Commission further finds that counties do incur increased costs mandated by the state pursuant to Government Code section 17514 for this program. However, as more fully discussed below, the state has amended cost-sharing mechanisms for some of the mandated activities that affect the total costs incurred by a county.

B. Increased costs mandated by the state for providing psychotherapy and other mental health services.

In *Handicapped and Disabled Students* (CSM 4282), the Commission determined that the costs incurred for providing psychotherapy or other mental health treatment services were subject to the Short-Doyle Act. Under the Short-Doyle Act, the state paid 90 percent of the total costs of mental health treatment services and the counties paid the remaining 10 percent. Thus, the Commission concluded that counties incurred increased costs mandated by the state in an amount that equaled 10 percent of the total psychotherapy or other mental health treatment costs. In 1993, the Sixth District Court of Appeal agreed with the Commission's conclusion.[88]

In 1991, the Legislature enacted realignment legislation that repealed the Short-Doyle Act and replaced the sections with the Bronzan-McCorquodale Act. (Stats. 1991, ch. 89, §§ 63 and 173.) The realignment legislation became effective on June 30, 1991. The parties have disputed whether the Bronzan-McCorquodale Act keeps the cost-sharing ratio, with the state paying 90 percent and the counties paying 10 percent, for the cost of psychotherapy or other mental health treatment services for special education pupils.

The Commission finds, however, that the Commission does not need to resolve that dispute for purposes of this test claim. Section 38 of Statutes 2002, chapter 1167 (Assem. Bill 2781) prohibits the funding provisions of the Bronzan-McCorquodale Act from affecting the responsibility of the state to fund psychotherapy and other mental health treatment services for handicapped and disabled pupils and requires the state to provide reimbursement to counties for those services for all allowable costs incurred. Section 38 also states the following:

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[86] "Challenge and Opportunity – An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California," Youth and Education Law Clinic, Stanford Law School, May 2004, page 20.

[87] Government Code section 17514; California Code of Regulations, title 2, section 1183.1.

[88] *County of Santa Clara v. Commission on State Mandates*, Sixth District Court of Appeal Case No. H009520, filed January 11, 1993 (unpubl.)

For reimbursement claims for services delivered in the 2001-02 fiscal year and thereafter, counties are *not* required to provide any share of those costs or to fund the cost of any part of these services with money received from the Local Revenue Fund [i.e. realignment funds]. (Emphasis added.)

In addition, Senate Bill 1895 (Stats. 2004, ch. 493, § 6) states that realignment funds used by counties for this program "are eligible for reimbursement from the state *for all allowable costs* to fund assessments, psychotherapy, and other mental health services . . . .," and that the finding by the Legislature is "declaratory of existing law." (Emphasis added.)

Therefore, beginning July 1, 2001, the 90 percent-10 percent cost-sharing ratio for the costs incurred for psychotherapy and other mental health treatment services no longer applies. Since the period of reimbursement for purposes of this reconsideration begins July 1, 2001, and section 38 of Statutes 2002, chapter 1167 is still in effect, all of the county costs for psychotherapy or other mental health treatment services are reimbursable, less any applicable offsets that are identified below.

C. Identification of offsets

Reimbursement under article XIII B, section 6 and Government Code section 17514 is required only for the increased costs mandated by the state. As determined by the California Supreme Court, the intent behind section 6 was to prevent the state from forcing new programs on local governments that require an increased expenditure by local government of their limited tax revenues.[89]

Government Code section 7576.5 states the following:

> If funds are appropriated to local educational agencies to support the costs of providing services pursuant to this chapter, the local educational agencies shall transfer those funds to the community mental health services that provide services pursuant to this chapter in order to reduce the local costs of providing these services. These funds shall be used exclusively for programs operated under this chapter and are offsetting revenues in any reimbursable mandate claim relating to special education programs and services.

Government Code section 7576.5 was added by the Legislature in 2003 (Stats. 2003, ch. 227) and became operative and effective on August 11, 2003. Thus, the Commission finds money received by counties pursuant to Government Code section 7576.5 shall be identified as an offset and deducted from the costs claimed.

In addition, any direct payments or categorical funds appropriated by the Legislature to the counties specifically for this program shall be identified as an offset and deducted from the costs claimed. This includes the appropriations made by the Legislature in the Budget Act of 2001, which appropriated funds to counties in the amount of $12,334,000

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[89] *County of Fresno v. State of California* (1991) 53 Cal.3d 482, 487; *County of San Diego, supra*, 15 Cal.4th at page 81.

and the $69 million appropriations in 2003 and 2004.[90] The appropriations made by the Legislature in 2001 and 2002, under Item 4440-295-0001 (appropriations of $46,944,000 and $1000, respectively), however, were expressly made pursuant to article XIII B, section 6 for purposes of reimbursing the original program approved by the Commission in CSM 4282, *Handicapped and Disabled Students*.[91] Since the Commission does not have jurisdiction in this test claim over the reimbursement of the statutes and regulations pled in the original test claim (CSM 4282), the Commission finds that the 2001 appropriation of $46,944,000 and the 2002 appropriation of $1000 are not required to be identified as an offset and deducted from the costs claimed here.

Furthermore, to the extent counties obtain private insurance proceeds with the consent of a parent for purposes of this program, such proceeds must be identified as an offset and deducted from the costs claimed. Federal law authorizes public agencies to access private insurance proceeds for services provided under the IDEA if the parent consents.[92] Thus, this finding is consistent with the California Supreme Court's decision in *County of Fresno v. State of California*. In the *County of Fresno* case, the court clarified that article XIII B, section 6 requires reimbursement by the state only for those expenses that are recoverable from tax revenues. Reimbursable costs under article XIII B, section 6, do not include reimbursement received from other non-tax sources.[93]

The Commission further finds that, to the extent counties obtain proceeds under the Medi-Cal program from either the state or federal government for purposes of this mandated program, such proceeds must be identified as an offset and deducted from the costs claimed. Federal law authorizes public agencies, with certain limitations, to use public insurance benefits, such as Medi-Cal, to provide or pay for services required under the IDEA.[94] Federal law limits this authority as follows:

> (2) With regard to services required to provide FAPE [free appropriate public education] to an eligible child under this part, the public agency-
>
> (i) May not require parents to sign up for or enroll in public insurance programs in order for their child to receive FAPE under Part B of the Act;
>
> (ii) May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but pursuant to paragraph (g)(2)

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[90] Statutes 2001, chapter 106, items 4440-131-0001; Statutes 2003, chapter 157, item 6110-161-0890, provision 17; Statutes 2004, chapter 208, item 6110-161-0890, provision 10.

[91] Statutes 2001, chapter 106, item 4440-295-0001; Statutes 2002, chapter 379, item 4440-295-0001.

[92] 34 Code of Federal Regulations section 300.142, subdivision (f).

[93] *County of Fresno, supra,* 53 Cal.3d at page 487.

[94] 34 Code of Federal Regulations section 300.142, subdivision (e).

of this section, may pay the cost that the parent would be required to pay;

(iii) May not use a child's benefits under a public insurance program if that use would

(A) Decrease available lifetime coverage or any other insured benefit;

(B) Result in the family paying for services that would otherwise be covered by the public insurance program and that are required for the child outside of the time the child is in school;

(C) Increase premiums or lead to the discrimination of insurance; or

(D) Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.[95]

According to the 2004 report published by Stanford Law School, 51.8 percent of the students receiving services under the test claim legislation are Medi-Cal eligible.[96] Thus, the finds to the extent counties obtain proceeds under the Medi-Cal program from the state or federal government for purposes of this mandated program, such proceeds must be identified as an offset and deducted from the costs claimed.[97]

Finally, Senate Bill 1895 (Stats. 2004, ch. 493, § 6), states that realignment funds under the Bronzan-McCorquodale Act that are used by a county for the Handicapped and Disabled Students program are not required to be deducted from the costs claimed. Section 6 of Senate Bill 1895 adds, as part of the Bronzan-McCorquodale Act, section 5701.6 to the Welfare and Institutions Code, which states in relevant part the following:

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[95] 34 Code of Federal Regulations section 300.142, subdivision (e)(2).

[96] "Challenge and Opportunity – An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California," Youth and Education Law Clinic, Stanford Law School, May 2004, page 20.

[97] In comments to the draft staff analysis, the County of Stanislaus states that counties share in the cost of Medi-Cal and, thus, the local Medi-Cal match should not be offset from the costs claimed under this program. The Commission agrees. Under the Medi-Cal program, "the state's share of costs of medical care and services, county administration, and fiscal intermediary services shall be determined pursuant to a plan approved by the Director of Finance and certified to by the director." (Welf. & Inst. Code, § 14158.5.) Thus, this analysis recommends that *to the extent* a county obtains proceeds under the Medi-Cal program from the state or federal government and that such proceeds pay for a portion of the county services provided to a pupil under the Handicapped and Disabled Students program, such funds are required to be identified as an offset and deducted from the costs claimed.

> Counties may utilize money received from the Local Revenue Fund [realignment] … to fund the costs of any part of those services provided pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code. *If money from the Local Revenue Fund is used by counties for those services, counties are eligible for reimbursement from the state for all allowable costs* to fund assessments, psychotherapy, and other mental health services allowable pursuant to Section 300.24 of Title 34 of the Code of Federal Regulations [IDEA] and required by Chapter 26.5 … of the Government Code. (Emphasis added.)

Senate Bill 1895 was a budget trailer bill to the 2004 budget. However, for reasons provided below, the language in Welfare and Institutions Code section 5701.6, that realignment funds are not required to be identified as an offset and deducted from the costs claimed, is retroactive and applies to the reimbursement period for this test claim, beginning July 1, 2001.

Welfare and Institutions Code section 5701.6, subdivision (b), states that "[t]his section is declaratory of existing law." Although a legislative statement that an act is declaratory of existing law is not binding on the courts, the courts have interpreted such language as legislative intent that the amendment applies to all existing causes of action. The courts have given retroactive effect to such a statute when there is no constitutional objection to its retroactive application. In this regard, the California Supreme Court has stated the following:

> A subsequent expression of the Legislature as the intent of the prior statute, although not binding on the court, may properly be used in determining the effect of a prior act. [Citation omitted.] Moreover, even if the court does not accept the Legislature's assurance that an unmistakable change in the law is merely a "clarification," the declaration of intent may still effectively reflect the Legislature's purpose to achieve a retrospective change. [Citation omitted.] Whether a statute should apply retrospectively or only prospectively is, in the first instance, a policy question of the legislative body enacting the statute. [Citation omitted.] Thus, where a statute provides that it clarifies or declares existing law, "[i]t is obvious that such a provision is indicative of a legislative intent that the amendment apply to all existing causes of action from the date of its enactment. In accordance with the general rules of construction, we must give effect to this intention unless there is some constitutional objection thereto." [Citations omitted.][98]

Thus, the Commission finds that realignment funds used by a county for this mandated program are not required to be identified as an offset and deducted from the costs claimed.

Accordingly, the Commission finds that the following revenue and/or proceeds must be identified as offsets and be deducted from the costs claimed:

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[98] *Western Security Bank v. Superior Court* (1997) 15 Cal.4th 232, 244.

- Funds received by a county pursuant to Government Code section 7576.5.
- Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes the appropriation made by the Legislature in the Budget Act of 2001, which appropriated funds to counties in the amounts of $12,334,000 (Stats. 2001, ch. 106, item 4440-131-0001), and the $69 million appropriations in 2003 and 2004 (Stats. 2003, ch. 157, item 6110-161-0890, provision 17; Stats. 2004, ch. 208, item 6110-161-0890, provision 10).
- Private insurance proceeds obtained with the consent of a parent for purposes of this program.
- Medi-Cal proceeds obtained from the state or federal government that pay for a portion of the county services provided to a pupil under the Handicapped and Disabled Students program in accordance with federal law.
- Any other reimbursement received from the federal or state government, or other non-local source.[99]

CONCLUSION

The Commission concludes that the test claim legislation imposes a reimbursable state-mandated program on counties pursuant to article XIII B, section 6 of the California Constitution and Government Code section 17514 for the increased costs in performing the following activities:

1. Interagency Agreements (Cal. Code Regs., tit. 2, § 60030)
    - The one-time activity of revising the interagency agreement with each local educational agency to include the following eight procedures:
        - Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code section 7575, subdivision (f). For purposes of this subdivision only, the term "appropriate" means any service identified in the pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(2).)
        - A host county to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)
        - Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)

[99] *County of Fresno, supra,* 53 Cal.3d at page 487; California Code of Regulations, title 2, section 1183.1, subdivision (a)(8).

- o At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)
- o The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)
- o The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)
- o The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)
- o Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)

2. Referral and Mental Health Assessments (Gov. Code, § 7576; Cal. Code Regs., tit. 2, §§ 60040, 60045)

- Work collaboratively with the local educational agency to ensure that assessments performed prior to referral are as useful as possible to the community mental health service in determining the need for mental health services and the level of services needed. (Gov. Code, § 7576, subd. (b)(1).)
- A county that receives a referral for a pupil with a different county of origin shall forward the referral within one working day to the county of origin. (Gov. Code, § 7576, subd. (g); Cal. Code Regs., tit. 2, § 60040, subd. (g).)
- If the county determines that a mental health assessment is not necessary, the county shall document the reasons and notify the parents and the local educational agency of the county determination within one day. (Cal Code Regs., tit. 2, § 60045, subd. (a)(1).)
- If the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral. (Cal. Code Regs., tit. 2, § 60045, subd. (a)(2).)
- Notify the local educational agency when an assessment is determined necessary. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)
- Provide the assessment plan to the parent. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)

- Report back to the referring local educational agency or IEP team within 30 days from the date of the receipt of the referral if no parental consent for a mental health assessment has been obtained. (Cal. Code Regs., tit. 2, § 60045, subd. (c).)
- Notify the local educational agency within one working day after receipt of the parent's written consent for the mental health assessment to establish the date of the IEP meeting. (Cal. Code Regs., tit. 2, § 60045, subd. (d).)
- Provide the parent with written notification that the parent may require the assessor to attend the IEP meeting to discuss the recommendation when the parent disagrees with the assessor's mental health service recommendation. (Cal. Code Regs., tit. 2, § 60045, subd. (f).)
- The county of origin shall prepare yearly IEP reassessments to determine the needs of a pupil. (Cal. Code Regs., tit. 2, § 60045, subd. (h).)

3. Transfers and Interim Placements (Cal. Code Regs., tit. 2, § 60055)
    - Following a pupil's transfer to a new school district, the county shall provide interim mental health services, as specified in the existing IEP, for thirty days, unless the parent agrees otherwise.
    - Participate as a member of the IEP team of a transfer pupil to review the interim services and make a determination of services.
4. Participate as a Member of the Expanded IEP Team When Residential Placement of a Pupil is Recommended (Gov. Code, § 7572.55; Cal Code Regs., tit. 2, § 60100)
    - When a recommendation is made that a child be placed in an out-of-state residential facility, the expanded IEP team, with the county as a participant, shall develop a plan for using less restrictive alternatives and in-state alternatives as soon as they become available, unless it is in the best educational interest of the child to remain in the out-of-state school. (Gov. Code, § 7572.55, subd. (c).)
    - The expanded IEP team, with the county as a participant, shall document the alternatives to residential placement that were considered and the reasons why they were rejected. (Cal. Code Regs., tit. 2, § 60100, subd. (c).)
    - The expanded IEP team, with the county as a participant, shall ensure that placement is in accordance with the admission criteria of the facility. (Cal. Code Regs., tit. 2, § 60100, subd. (j).)
    - When the expanded IEP team determines that it is necessary to place a pupil who is seriously emotionally disturbed in residential care, counties shall ensure that: (1) the mental health services are specified in the IEP in accordance with federal law, and (2) the mental health services are provided by qualified mental health professionals. (Cal. Code Regs., tit. 2, § 60100, subd. (i).)

5. Case Management Duties for Pupils Placed in Residential Care (Cal. Code Regs., tit. 2, §§ 60100, 60110)

   - Coordinate the residential placement plan of a pupil with a disability who is seriously emotionally disturbed as soon as possible after the decision has been made to place the pupil in residential placement. The residential placement plan shall include provisions, as determined in the pupil's IEP, for the care, supervision, mental health treatment, psychotropic medication monitoring, if required, and education of the pupil. (Cal. Code Regs., tit, 2, § 60110, subd, (b)(1).)
   - When the IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a community treatment facility, the lead case manager shall ensure that placement is in accordance with admission, continuing stay, and discharge criteria of the community treatment facility. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(3).)
   - Identify, in consultation with the IEP team's administrative designee, a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost-effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment. (Cal. Code Regs, tit. 2, §§ 60100, subd. (e), 60110, subd. (c)(2).)
   - Document the determination that no nearby placement alternative that is able to implement the IEP can be identified and seek an appropriate placement that is as close to the parents' home as possible. (Cal. Code Regs., tit. 2, § 60100, subd. (f).)
   - Notify the local educational agency that the placement has been arranged and coordinate the transportation of the pupil to the facility if needed. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(7).)
   - Facilitate placement authorization from the county's interagency placement committee pursuant to Welfare and Institutions Code section 4094.5, subdivision (e)(1), by presenting the case of a pupil with a disability who is seriously emotionally disturbed prior to placement in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(11).)
   - Evaluate every 90 days the continuing stay criteria, as defined in Welfare and Institutions Code section 4094, of a pupil placed in a community treatment facility every 90 days. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(8).)
   - Schedule and attend the next expanded IEP team meeting with the expanded IEP team's administrative designee within six months of the residential placement of a pupil with a disability who is seriously emotionally disturbed and every six months thereafter as the pupil remains in residential placement. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(10).)

6. Authorize Payments to Out-Of-Home Residential Care Providers (Cal. Code Regs., tit. 2, § 60200, subd. (e))

   - Authorize payments to residential facilities based on rates established by the Department of Social Services in accordance with Welfare and Institutions Code sections 18350 and 18356.

7. Provide Psychotherapy or Other Mental Health Treatment Services (Cal. Code Regs., tit. 2, §§ 60020, subd. (i), 60050, subd. (b), 60200, subd. (c))

   - The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)
   - The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)
   - Provide case management services to a pupil when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
   - Provide individual or group psychotherapy services, as defined in Business and Professions Code section 2903, when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
   - Provide medication monitoring services when required by the pupil's IEP. "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subds. (f) and (i).)
   - Notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of a service, or when the pupil is no longer participating in treatment. ((Cal. Code Regs., tit. 2, § 60050, subd. (b).)

The Commission further concludes that the following revenue and/or proceeds must be identified as offsets and deducted from the costs claimed:

- Funds received by a county pursuant to Government Code section 7576.5.
- Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes the appropriation made by the Legislature in the Budget Act of 2001, which appropriated funds to counties in the amounts of $12,334,000 (Stats. 2001, ch. 106, items 4440-131-0001), and the $69 million appropriations in 2003 and

2004 (Stats. 2003, ch. 157, item 6110-161-0890, provision 17; Stats. 2004, ch. 208, item 6110-161-0890, provision 10).

- Private insurance proceeds obtained with the consent of a parent for purposes of this program.
- Medi-Cal proceeds obtained from the state or federal government that pay for a portion of the county services provided to a pupil under the Handicapped and Disabled Students program in accordance with federal law.
- Any other reimbursement received from the federal or state government, or other non-local source.

The reimbursement period for this test claim begins July 1, 2001.[100]

Finally, any statutes and or regulations that were pled in this test claim that are not identified above do not constitute a reimbursable state-mandated program.

[100] Government Code section 17557, subdivision (e).

ITEM 14

PROPOSED AMENDMENTS TO PARAMETERS AND GUIDELINES

Government Code Sections 7570-7588

Statutes 1984, Chapter 1747 (Assem. Bill No. 3632);
Statutes 1985, Chapter 1274 (Assem. Bill No. 882)

California Code of Regulations, Title 2, Sections 60000-60610 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28))

Counties of Los Angeles and Stanislaus, Requestors

Handicapped & Disabled Students **(CSM 4282)**
00-PGA-03; 00-PGA-04

EXECUTIVE SUMMARY

Procedural Background

This is a request to amend the parameters and guidelines for *Handicapped and Disabled Students* (CSM 4282). The Counties of Los Angeles and Stanislaus filed separate requests to amend the parameters and guidelines for this program in 2001. The requests to amend the parameters and guidelines were scheduled on the Commission's March 2002 hearing calendar. At the request of the counties, however, the item was taken off calendar. In April 2003, after several pre-hearing conferences and requests to postpone this matter, the counties filed a consolidated draft of proposed amendments to the parameters and guidelines, and have requested that the Commission consider this 2003 submittal as their consolidated request.

While these requests were pending, the counties filed the *Handicapped and Disabled Students II* test claim (02-TC-40/02-TC-49). In 2003, the parties agreed to postpone the hearing on the request to amend the parameters and guidelines in CSM 4282 until after the Commission decided *Handicapped and Disabled Students II*. In addition, in 2004, the Legislature directed the Commission to reconsider the Statement of Decision in *Handicapped and Disabled Students* (CSM 4282). (Stats. 2004, ch. 493 (SB 1895).) The Commission adopted the Statement of Decision on reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10) and the decision in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) on May 26, 2005.

Staff notes that the majority of written comments on this item were filed before the Commission adopted the 2005 decisions on the reconsideration of *Handicapped and Disabled Students* and *Handicapped and Disabled Students II*. As described in the analysis, the 2005 decisions impact the analysis of the requests to amend the original parameters and guidelines.

This item was again scheduled for the Commission's October 26, 2006 hearing.[1] The staff analysis recommended that the Commission approve only the requests to amend the indirect cost language and the request to specifically identify the offsetting revenue identified by the Commission in the decisions on reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10) and *Handicapped and Disabled Students II* (02-TC-40/02-TC-49). The staff analysis further concluded that the other requests to add to or amend the reimbursable activities were not consistent with the Statement of Decision in CSM 4282 and, thus, must be denied.

On October 25, 2006, the State Controller's Office requested a postponement of the hearing and an opportunity to file additional comments. The Controller's request stated in relevant part the following:

> Item 14 clarified indirect costs and offsetting revenues, and allows claimants to file amended claims from July 1, 2000, through June 30, 2004. Based on recent comments we have received from counties as to the impact the changes have on prior claims, we believe that additional time is needed to fully evaluate the proposed changes.

The Controller's request was approved for good cause. On November 6, 2006, the Controller filed additional comments recommending that the Commission deny the counties' requests to amend the parameters and guidelines, including the language regarding the reimbursement of indirect costs and the proposed amendments to specifically identify offsetting revenue, on the ground that the staff analysis on the proposed amendments do not add any additional costs or activities eligible for reimbursement.[2]

Test Claim Statutes and Regulations

Generally, the test claim statutes and regulations implement federal law that requires states to guarantee to disabled pupils the right to receive a free and appropriate public education that emphasizes special education and related services designed to meet the pupil's unique educational needs. The mechanism for providing special education services under federal law is the individualized education program, or IEP. An IEP is a written statement developed after an evaluation of the pupil in all areas of suspected disability and may provide for related services including mental health and psychological services.

Before the enactment of the test claim statutes and regulations, the state adopted a plan to comply with federal law. The responsibility for supervising special education and related services was delegated to the Superintendent of Public Instruction. Local educational agencies (LEAs) were financially responsible for the provision of mental health services required by a pupil's IEP.

The test claim statutes and regulations, which became effective on July 1, 1986, shifted the responsibility and funding of mental health services required by a pupil's IEP to

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[1] See Exhibit O, Item 14, October 26, 2006 Commission Hearing.

[2] See Exhibit P.

county mental health departments. The Commission approved the test claim in 1990, with a reimbursement period beginning July 1, 1986.

Since the original decision was adopted, the Commission has adopted two subsequent decisions that impact the analysis of this request; namely, the reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10) and *Handicapped and Disabled Students II* (02-TC-40/02-TC-49).

The Counties' Request

The counties request that the original parameters and guidelines for the Handicapped and Disabled Students program be amended, retroactively back to the original reimbursement period of July 1, 1986, as follows:

- delete all references to the Short-Doyle cost-sharing mechanism for providing psychotherapy or other mental health services;
- add a cost provision to reimburse counties for residential board and care for in-state placement of pupils in residential facilities;
- amend the mental health services provided by counties to special education students in accordance with current law;
- amend the language regarding the reimbursement of indirect costs; and
- amend the offsetting revenue paragraph to include revenue received through Medi-cal, private pay insurance, state categorical funding (Item 4440-131-0001 of the State Budget Act), Healthy Families Program, and federal IDEA funding to be provided to backfill loss of state funding for the program.

Staff Analysis

For the reasons provided in the analysis, staff finds that if the Commission approves any of the counties' requests on this matter, the reimbursement period for the new amended portions of the parameters and guidelines would be from July 1, 2000, through and including June 30, 2004 only.[3]

Staff recommends that the Commission approve only the request to amend the language regarding offsetting revenue. The language proposed for section VIII, Offsetting Revenues and Other Reimbursements, is consistent with the Commission's identification of offsetting revenue in the reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10) and *Handicapped and Disabled II* (02-TC-40/02-TC-49), and corrects a legal error contained in the original parameters and guidelines (CSM 4282), that Medi-Cal and private insurance proceeds cannot be used as offsetting revenue. As determined by the Commission in the reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10), federal law, under specified circumstances, allows agencies to use these proceeds to pay for this program. Thus, staff recommends that the Commission correct this section and specifically identify the offsetting revenue applicable to this program, consistent with its prior decisions.

[3] California Code of Regulations, title 2, section 1183.2.

Staff further finds that the requests to add to or amend the reimbursable activities are not consistent with the Statement of Decision and, thus, must be denied. The analysis regarding the reimbursable activities has not changed since the October 2006 final staff analysis.

Staff further finds that the proposed indirect cost language does not identify any additional costs that could not have been previously claimed by counties and, thus, it is not necessary to amend section VI, Claim Preparation.

If the Commission approves the request to amend the parameters and guidelines in any manner, the State Controller's Office will be required to prepare and issue revised claiming instructions 60 days after receiving the amended parameters and guidelines. (Gov. Code, § 17558, subd. (c).)

Conclusion and Staff Recommendation

Staff recommends that the Commission adopt the staff analysis and the proposed parameters and guidelines, as modified by staff, which begins on page 33, to incorporate the language regarding offsetting revenue. The proposed amendments are effective for the reimbursement period beginning July 1, 2000, through and including June 30, 2004.

Staff further recommends that the Commission authorize staff to make any non-substantive, technical corrections to the parameters and guidelines following the hearing.

Requestors

Counties of Los Angeles and Stanislaus

Chronology

07/30/87	County of Santa Clara files test claim on *Handicapped and Disabled Students* (CSM 4282)
04/26/90	Commission adopts Statement of Decision (CSM 4282)
06/25/90	County of Santa Clara files petition for writ of mandate challenging Commission decision; trial court denies the petition, sustaining the Commission's decision
08/22/91	Commission adopts parameters and guidelines
01/11/93	Sixth District Court of Appeal affirms the Commission decision
08/29/96	Commission adopts Amended parameters and guidelines
06/04/01	County of Los Angeles files request to amend parameters and guidelines
06/22/01	County of Stanislaus files request to amend parameters and guidelines
07/05/01	County of Los Angeles requests pre-hearing conference
07/17/01	County of Stanislaus requests that items be heard separately
07/20/01	County of Los Angeles requests that the items be heard separately
08/03/01	Legislative Analyst's Office submits comments
08/06/01	Department of Finance submits comments
10/04/01	County of Stanislaus files response to Department of Finance comments
10/05/01	County of Los Angeles files review of State Agency comments
10/05/01	Department of Finance resubmits comments of August 6, 2001
10/24/01	Department of Finance files comments on "board and care"
10/25/01	Pre-hearing conference held
11/07/01	State Controller's Office files comments
11/09/01	County of Los Angeles requests extension of time to file rebuttal comments
11/09/01	County of Stanislaus requests extension of time to file rebuttal comments
12/07/01	County of Stanislaus requests that the pre-hearing conference be rescheduled
12/13/01	County of Los Angeles files review of State Agency comments
12/13/01	County of Stanislaus files response to State Controller's Office comments
12/18/01	Counties of Los Angeles and Stanislaus request second pre-hearing conference
01/25/02	County of Stanislaus files supplemental filing

02/15/02	Interested person, Catherine Camp, Former Executive Director of California Association of Mental Health Directors, files comments
02/22/02	Second pre-hearing conference held
02/22/02	County of Santa Cruz files comments
03/06/02	State Controller's Office files additional comments
03/07/02	Department of Finance files comments responding to the comments from the County of Santa Cruz
03/20/02	Final staff analysis issued for the March 28, 2002 Commission Hearing
03/25/02	Counties of Los Angeles and Stanislaus request that hearing be postponed and request an extension of time to file comments on the staff analysis; Requests granted with a new hearing date scheduled for May 23, 2002
03/28/02	Lakeside Union School District files comments in support of the County of Stanislaus' request to amend the parameters and guidelines
04/02/02	County of Los Angeles requests that the hearing be postponed until June 27, 2002 and requests an extension of time to file comments on the staff analysis; Requests granted
05/13/02	County of Los Angeles files comments on staff analysis
05/20/02	County of Stanislaus files comments on staff analysis
06/18/02	Counties of Los Angeles and Stanislaus request that the hearing be postponed until October 24, 2002, after the State Budget is adopted; Request granted
09/30/02	Statutes 2002, chapter 1167 (AB 2781) enacted as urgency legislation; Counties of Los Angeles and Stanislaus request additional time to submit revised proposals in light of AB 2781; Requests granted
11/08/02	County of Stanislaus adds Statutes 2002, chapter 1167 (AB 2781) to the record
12/18/02	County of Los Angeles files proposed revisions to the parameters and guidelines
01/22/03	County of Stanislaus files proposed changes to the parameters and guidelines and requests a pre-hearing conference
02/26/03	Pre-hearing conference held; the requestors agreed to file a consolidated draft of proposed amendments to the parameters and guidelines
04/04/03, 04/11/03	Counties of Los Angeles and Stanislaus file consolidated draft of proposed amendments to the parameters and guidelines
05/14/03	Department of Finance requests extension of time to file comments on consolidated draft of proposed amendments to the parameters and guidelines; Request granted for good cause
06/27/03, 06/30/03	County of Stanislaus files test claim entitled *Handicapped and Disabled Students II* (02-TC-40); County of Los Angeles files test claim entitled *County Mental Health Services for Pupils with Disabilities* (02-TC-49); Test claims ultimately consolidated as *Handicapped and Disabled Students II* (02-TC-40/02-TC-49)

06/30/03 Department of Finance files comments on consolidated draft of proposed amendments to the parameters and guidelines

07/30/03 County of Los Angeles files review of State Agency comments

09/24/03 Pre-hearing conference held

11/21/03 Parties agree to waive the procedural requirements pursuant to Government Code section 17554 and to postpone hearing until after *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) is decided

01/07/04 Commission receives signed agreements from parties to postpone hearing and mails final stipulation out to the parties

09/13/04 Statutes 2004, Chapter 493(SB 1895), is enacted and directs the Commission to reconsider *Handicapped and Disabled Students* (CSM 4282);
File is designated 04-RL-4282-10

05/26/05 Commission adopts Statement of Decision on the reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10)

05/26/05 Commission adopts Statement of Decision in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49)

12/09/05 Commission adopts parameters and guidelines for *Handicapped and Disabled Students II* (02-TC-40/02-TC-49). Reimbursement period begins July 1, 2001

01/26/06 Commission adopts parameters and guidelines for *Handicapped and Disabled Students* (04-RL-4282-10) and amends parameters and guidelines in *Handicapped and Disabled Students* (CSM 4282) by ending the period of reimbursement for costs incurred through and including June 30, 2004. Costs incurred beginning July 1, 2004, shall be claimed under the parameters and guidelines for the Commission's decision on reconsideration, *Handicapped and Disabled Students* (04-RL-4282-10)

05/03/06 Draft staff analysis issued

05/24/06 Pre-hearing conference held

07/21/06 Technical corrections made to parameters and guidelines for the Reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10) and *Handicapped and Disabled Students II* (02-TC-40/02-TC-49)

10/25/06 State Controller's Office requests that the item, set for the Commission's October 26, 2006 hearing, be postponed. Request granted for good cause.

11/06/06 State Controller's Office files comments recommending that the Commission deny the requests to amend the parameters and guidelines regarding indirect costs and offsetting revenue

Background

This is a request to amend the parameters and guidelines for *Handicapped and Disabled Students* (CSM 4282). The Counties of Los Angeles and Stanislaus filed separate requests to amend the parameters and guidelines for this program in 2001. The requests

to amend the parameters and guidelines were scheduled on the Commission's March 2002 hearing calendar. At the request of the counties, however, the item was postponed. In April 2003, after several pre-hearing conferences and requests to postpone this matter, the counties filed a consolidated draft of proposed amendments to the parameters and guidelines, and requested that the Commission consider this 2003 submittal as their consolidated request.

In November 2003, the parties agreed to waive the procedural requirements of the Government Code (Gov. Code, § 17554) and postpone the hearing on this item until after *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) was decided.

The counties request that the original parameters and guidelines for the Handicapped and Disabled Students program be amended, retroactively back to the original reimbursement period of July 1, 1986, as follows:

- delete all references to the Short-Doyle cost-sharing mechanism for providing psychotherapy or other mental health services;
- add a cost provision to reimburse counties for residential board and care for in-state placement of pupils in residential facilities;
- amend the mental health services provided by counties to special education students in accordance with current law;
- amend the language regarding the reimbursement of indirect costs; and
- amend the offsetting revenue paragraph to include revenue received through Medi-cal, private pay insurance, state categorical funding (Item 4440-131-0001 of the State Budget Act), Healthy Families Program, and federal IDEA funding to be provided to backfill loss of state funding for the program.

For the reasons provided below, staff finds that if the Commission approves any of the counties' requests on this matter, the reimbursement period for the new amended portions of the parameters and guidelines would be from July 1, 2000, through and including June 30, 2004 only.[4] In addition, staff recommends that the Commission approve only the requests to amend the language regarding offsetting revenue. The other requests to add to or amend the reimbursable activities are not consistent with the Statement of Decision and, thus, must be denied.

Summary of the Mandate

The Commission adopted the Statement of Decision on the *Handicapped and Disabled Students* program in 1990 (CSM 4282). The test claim on *Handicapped and Disabled Students* (CSM 4282) was filed on Government Code section 7570 and following, as added and amended by Statutes 1984, chapter 1747, and Statutes 1985, chapter 1274, and on the initial emergency regulations adopted by the Departments of Mental Health and Education to implement this program (Cal. Code Regs., tit. 2, div. 9, §§ 60000-60610 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986

[4] California Code of Regulations, title 2, section 1183.2.

(Register 86, No. 1) and re-filed June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)).

Generally, the test claim legislation implements federal law that requires states to guarantee to disabled pupils the right to receive a free and appropriate public education that emphasizes special education and related services designed to meet the pupil's unique educational needs.[5] The mechanism for providing special education services under federal law is the individualized education program, or IEP. An IEP is a written statement developed after an evaluation of the pupil in all areas of suspected disability and may provide for related services including mental health and psychological services.[6]

Before the enactment of the test claim legislation, the state adopted a plan to comply with federal law. The responsibility for supervising special education and related services was delegated to the Superintendent of Public Instruction. Local educational agencies (LEAs) were financially responsible for the provision of mental health services required by a pupil's IEP.[7]

The test claim legislation, which became effective on July 1, 1986, shifted the responsibility and funding of mental health services required by a pupil's IEP to county mental health departments.

The Commission approved the test claim and found that the activities of providing mental health assessments, participation in the IEP process, psychotherapy, and other mental health services were reimbursable under article XIII B, section 6 of the California Constitution. Activities related to assessments and IEP responsibilities were found to be 100% reimbursable. Psychotherapy and other mental health treatment services were found to be 10% reimbursable due to the funding methodology in existence under the Short-Doyle Act for local mental health services.

The parameters and guidelines for *Handicapped and Disabled Students* (CSM 4282) were adopted in August 1991, and amended in 1996, and have a reimbursement period beginning July 1, 1986 and ending June 30, 2004.[8] The parameters and guidelines authorize reimbursement for the following activities:

A. One Hundred (100) percent of any costs related to IEP Participation, Assessment, and Case Management:

   1. The scope of the mandate is one hundred (100) percent reimbursement, except that for individuals billed to Medi-Cal only, the Federal Financing

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[5] See federal Rehabilitation Act of 1973 and the Individuals with Disabilities Education Act (IDEA).

[6] Title 20 United States Code sections 1400 et seq.

[7] Education Code sections 56000 et seq.

[8] On January 26, 2006, the Commission amended the parameters and guidelines in Handicapped and Disabled Students (CSM 4282) by ending the period of reimbursement on June 30, 2004. Beginning July 1, 2004, claims shall be filed pursuant to the parameters and guidelines and claiming instructions for the Reconsideration of Handicapped and Disabled Students (04-RL-4282-10).

Participation portion (FFP) for these activities should be deducted from reimbursable activities not subject to the Short-Doyle Act.

2. For each eligible claimant, the following cost items are one hundred (100) percent reimbursable (Gov. Code, § 7572, subd. (d)(1)):

   a. Whenever an LEA refers an individual suspected of being an "individual with exceptional needs" to the local mental health department, mental health assessment and recommendation by qualified mental health professionals in conformance with assessment procedures set forth in Article 2 (commencing with section 56320) of Chapter 4 of part 30 of Division 4 of the Education Code, and regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, including but not limited to the following mandated services:

      i. interview with the child and family,

      ii. collateral interviews, as necessary,

      iii. review of the records,

      iv. observation of the child at school, and

      v. psychological testing and/or psychiatric assessment, as necessary.

   b. Review and discussion of mental health assessment and recommendation with parent and appropriate IEP team members. (Gov. Code, § 7572, subd. (d)(1).)

   c. Attendance by the mental health professional who conducted the assessment at IEP meetings, when requested. (Gov. Code, § 7572, subd. (d)(1).)

   d. Review by claimant's mental health professional of any independent assessment(s) submitted by the IEP team. (Gov. Code, § 7572, subd. (d)(2).)

   e. When the written mental health assessment report provided by the local mental health program determines that an "individual with special needs" is "seriously emotionally disturbed," and any member of the IEP team recommends residential placement based upon relevant assessment information, inclusion of the claimant's mental health professional on that individual's expanded IEP team.

   f. When the IEP prescribes residential placement for an "individual with exceptional needs" who is "seriously emotionally disturbed," claimant's mental health personnel's identification of out-of-home placement, case management, six month review of IEP, and expanded IEP responsibilities. (Gov. Code, § 7572.5.)

   g. Required participation in due process hearings, including but not limited to due process hearings.

3. One hundred (100) percent of any administrative costs related to IEP Participation, Assessment, and Case Management, whether direct or indirect.

B. Ten (10) percent of any costs related to mental health treatment services rendered under the Short-Doyle Act:

1. The scope of the mandate is ten (10) percent reimbursement.

2. For each eligible claimant, the following cost items, for the provision of mental health services when required by a child's individualized education program, are ten (10) percent reimbursable (Gov. Code, § 7576):

   a. individual therapy,

   b. collateral therapy and contacts,

   c. group therapy,

   d. day treatment, and

   e. mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.

3. Ten (10) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

In 1993, the Sixth District Court of Appeal, in *County of Santa Clara v. Commission on State Mandates*, issued an unpublished decision that upheld the Commission's decision, including the percentage of reimbursements, on the *Handicapped and Disabled Students* program.[9]

<u>Subsequent Commission Decisions</u>

Since the filing of the requests to amend the parameters and guidelines for *Handicapped and Disabled Students* (CSM 4282), the Commission has adopted two Statements of Decision and parameters and guidelines that impact the analysis of these requests.

In 2004, the Legislature, in Statutes 2004, chapter 493 (Sen. Bill No. 1895), directed the Commission to reconsider *Handicapped and Disabled Students* (CSM 4282). In May 2005, the Commission adopted a Statement of Decision, as directed by the Legislature that reconsiders *Handicapped and Disabled Students*, CSM 4282. (04-RL-4282-10.) The Commission determined that the original Statement of Decision correctly concluded that the test claim statutes and regulations imposes a reimbursable state-mandated program on counties pursuant to article XIII B, section 6. However, the Commission concluded that the 1990 Statement of Decision did not fully identify all of the activities mandated by the state or the offsetting revenue applicable to the program. Thus, the Commission modified the Statement of Decision in *Handicapped and Disabled*

[9] *County of Santa Clara v. Commission on State Mandates*, Sixth District Court of Appeal Case No. H009520, filed January 11, 1993 (p. 1415.)

Students (CSM 4282), for reimbursement claims filed for the 2004-2005 fiscal year and thereafter, by identifying the activities expressly required by the test claim statutes and regulations and the offsetting revenue applicable to the program.

Parameters and guidelines for the reconsidered *Handicapped and Disabled Students* program (04-RL-4282-10) were adopted by the Commission in January 2006 and corrected in July 2006, and have a reimbursement period beginning July 1, 2004. In addition, the Commission amended the original parameters and guidelines for CSM 4282 by ending the period of reimbursement for costs incurred through and including June 30, 2004. Costs incurred beginning July 1, 2004, shall be claimed under the parameters and guidelines for the Commission's decision on reconsideration, *Handicapped and Disabled Students* (04-RL-4282-10).

The Commission also adopted a Statement of Decision in May 2005 on *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), a test claim addressing the amendments, enacted between the years 1986 and 2002, to the initial statutes and regulations. The reimbursement period for the activities approved by the Commission in *Handicapped and Disabled Students II* begins July 1, 2001. In December 2005, the Commission adopted parameters and guidelines for *Handicapped and Disabled Students II.* A technical correction was made to the parameters and guidelines in July 2006.

The relevant periods of reimbursement for these decisions are in Table 1 below.

Table 1

Claims	**Periods of Reimbursement**
Handicapped and Disabled Students (CSM 4282)	July 1, 1986, through June 30, 2004
Counties' request to amend *Handicapped and Disabled Students* (CSM 4282)	July 1, 2000 (Potential)
Handicapped and Disabled Students II (02-TC-40/02-TC-49)	July 1, 2001
Reconsideration of Handicapped and Disabled Students (04-RL-4282-10)	July 1, 2004

Consolidated parameters and guidelines covering all the activities are proposed for costs incurred beginning in fiscal year 2006-2007. The proposed consolidated parameters and guidelines are in Item 13 for the October 26, 2006 hearing.

Position of the Requestors

The counties request that the parameters and guidelines be amended, retroactively back to the original reimbursement period of July 1, 1986, as follows:

- Delete all references to the Short-Doyle cost-sharing mechanism for providing psychotherapy or other mental health services. The counties contend that the Short-Doyle Act was repealed on July 1, 1991, and, thus, counties are entitled to 100 percent reimbursement for providing psychotherapy or other mental health

treatment services. The counties also rely on Statutes 2002, chapter 1167 (AB 2781), which directed the State Controller's Office to not dispute reimbursement claims, filed in fiscal years up to and including the 2000-2001 fiscal year, with respect to the percentage of reimbursement the county claimed for allowable mental health treatment services.

- Add a cost provision to reimburse counties for 60 percent of the residential board and care costs for in-state placement of pupils in residential facilities. The counties contend that the joint regulations adopted by the Departments of Mental Health and Education require counties to provide assessment, treatment, case management and residential care services, including room, board, care and supervision.
- Amend the mental health services provided by counties to special education students in accordance with current law. The counties request the addition of the following language, which includes activities for medication monitoring, to the parameters and guidelines:

  > For each eligible claimant, the following cost items, for the provision of services when required by a child's individualized education program in accordance with Section 7572(d) of the Government Code: psychotherapy (including outpatient crisis-intervention psychotherapy provided in the normal course of IEP services when a pupil exhibits acute psychiatric symptoms, which, if untreated, presents an imminent threat to the pupil) as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management are reimbursable (Government Code 7576). "Medication monitoring" includes medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness.[10]

- Amend the language regarding the reimbursement of indirect costs to comply with previously adopted boilerplate language.
- Amend the offsetting revenue paragraph to include revenue received through Medi-cal, private pay insurance, state categorical funding (Item 4440-131-0001 of the State Budget Act), Healthy Families Program, and federal IDEA funding to provided to backfill loss of state funding for the program.

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[10] Exhibit A, consolidated request to amend Parameters and Guidelines, page 111.

State Agency Comments

Department of Finance

On June 30, 2003, the Department of Finance filed comments on the consolidated request to amend the parameters and guidelines as follows:

> Finance continues to hold the position that the original Statement of Decision and existing Parameters and Guidelines are correct based upon the statutes that were the basis of the test claim. The Parameters and Guidelines state that any mental health treatment required by an Individual Education Plan for special education pupils is subject to the original Short-Doyle cost sharing formula and only the county's Short-Doyle share (i.e. 10 percent) of the mental health treatment costs is reimbursable as a cost mandated by the state. The proposed amendments to the Parameters and Guidelines to eliminate references to the Short-Doyle Act and modify the cost-sharing ratio for mental health treatment services are inconsistent with the existing Statement of Decision (please reference the Finance response to comments submitted by the Counties of Los Angeles and Stanislaus dated June 7, 2002). Finance is aware that the Legislature modified statute relating to this mandate in Chapter 1167, Statutes 2002 (AB 2781, Oropeza). Finance defers to the Commission staff on the issue of whether the Parameters and Guidelines can be amended based on the new statute absent findings by the Commission or a new test claim should be filed in order to consider the effects of these changes. There is clearly new legislative direction on this issue, and it is not clear what authority the Commission staff has to expand the scope of reimbursement and increase expenditures without findings by the Commission on the new statute.
>
> Finance believes that Section 41 of Chapter 1167, Statutes 2002, affected the Handicapped and Disabled Students mandate retroactively, and forgave audit exceptions identified by the State Controller's Office (SCO). The language specified that claims submitted to the SCO for reimbursement are not subject to dispute by the SCO regarding the percentage of reimbursement claimed. In 2001, the SCO identified audit exceptions where counties claimed reimbursement in excess of amounts allowed pursuant to the existing Parameters and Guidelines issued by the Commission. Counties are currently allowed to claim reimbursement of 10 percent of the cost to provide mental health treatment services to children consistent with the needs identified in the Individual Education Plan. The audits conducted by the SCO revealed that some counties claimed 100 percent of the allowable costs. These audit exceptions in part lead to the proposed amendments [to] the Parameters and Guidelines coming before the Commission. The SCO did not complete the statewide audit of the Handicapped and Disabled Students mandate claims pending resolution of the issue by the Commission.
>
> Furthermore, Section 38 of Chapter 1167, Statutes 2002, affected the Handicapped and Disabled Students mandate prospectively, and allows all

> counties to claim 100 percent of allowable costs for services delivered in 2001-02 and subsequent years. The language changed existing statute, which is the basis of the existing Statement of Decision, to increase the percentage of reimbursement for mental health treatment from 10 percent to 100 percent, but because the audit was not completed, it is unclear how many counties were already claiming 100 percent.
>
> Finance also concluded that the proposed amendments to the Parameters and Guidelines continue to appear to be an effort to circumvent the established rate setting methodology that authorizes the California Department of Social Services (DSS) to set reasonable board and care rates for in-state placement facilities based on specified criteria (please reference the Finance response to the proposed amendments to the Parameters and Guidelines dated October 24, 2001). Counties should remain responsible for their share of costs for instate out-of-home placement of special education pupils. Furthermore, the proposed amendments are too broad in that they specify that reimbursement is allowable for residential services costs "in excess of the DSS 40 percent share of the DSS allowable room and board payments." Such language would allow 60 percent of the costs in excess of the DSS allowable room and board payments to be reimbursed in addition to the 60 percent local share of cost of the DSS allowable room and board payments. Finance recommends specifying that only the 60 percent local share of DSS allowable room and board payments is reimbursable.…[11]

<u>Legislative Analyst's Office</u>

The Legislative Analyst's Office (LAO) submitted comments on August 6, 2001 that stated in relevant part the following:

> …the intent of the 1991 program realignment was to replace state funding under the Short-Doyle program with a comparable amount of funding from new tax revenues. Elimination of the Short-Doyle funding program, therefore, should not be construed as ending state support for local mental health programs for pupils. Instead, state support for this program has been transferred from the Short-Doyle program to state realignment funds.[12]

In addition, the LAO recommends that two additional funding sources should be identified in the parameters and guidelines as offsets to reimbursement claims. These funding sources include: 1) Budget Act funds allocated under item 4440-131-0001 which provides categorical funding for assessment, treatment and case management under AB 3632; and, 2) Healthy Families Program funds which provide mental health services to children with serious emotional disturbances.

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[11] Exhibit B, Department of Finance June 30, 2003 comments.

[12] Exhibit G, Legislative Analyst's Office August 6, 2001 comments.

State Controller's Office

2006 Comments. On October 25, 2006, the State Controller's Office requested a postponement of the hearing and an opportunity to file additional comments. The Controller's request stated in relevant part the following:

> Item 14 [of the October 26, 2006 hearing calendar] clarified indirect costs and offsetting revenues, and allows claimants to file amended claims from July 1, 2000, through June 30, 2004. Based on recent comments we have received from counties as to the impact the changes have on prior claims, we believe that additional time is needed to fully evaluate the proposed changes.

The Controller's request was approved for good cause. On November 6, 2006, the Controller filed additional comments recommending that the Commission deny the counties' requests to amend the parameters and guidelines, including the language regarding the reimbursement of indirect costs and the proposed amendments specifically identifying offsetting revenue, on the ground that the staff analysis on the proposed amendments do not add any additional costs or activities eligible for reimbursement.

Prior Comments. The SCO submitted comments and proposed language to the Parameters and Guidelines on November 7, 2001. The SCO proposed changes to Sections I, II, V, and VI to update and clarify the Parameters and Guidelines related to the repeal of the Short-Doyle Act. While the SCO's proposed language updates the Parameters and Guidelines relative to the repeal of the Short-Doyle Act, it does not change the cost-sharing formula or the 10% reimbursement limitation for certain activities. In addition, the SCO proposes new language for Section VIII regarding offsetting savings. The SCO's comments stated in part the following:

> [t]he SCO believes that changes in statutory provisions continue to require the State to fund 90% of the net mental health treatment services rendered under the Short-Doyle Act (as replaced by the Bronzan-McCorquodale Act of 1991), even though the state has not appropriated sufficient moneys to fund the required 90% in the past years. Therefore, the SCO believes that only 10% of the net mental health treatment services rendered under the Bronzan-McCorquodale Act when required by a child's IEP is reimbursable under this mandate.
>
> Until a new Statement of Decision is adopted, the reimbursable portion of net costs related to mental health treatment services rendered under the Short-Doyle Act (as replaced by the Bronzan-McCorquodale Act) when required by a child's IEP appears to be limited to 10%.[13]

On March 6, 2002, the SCO submitted final comments on the proposed amendments. Their comments stated in part the following: "It has been our position that the changes that the amendments attempt to make are contrary to the language of the Statement of Decision, and thus impermissible. Ultimately we believe that this case more properly

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[13] Exhibit L, SCO November 7, 2001 comments.

involves an increased cost, and thus must be pursued via a test claim. Thus, these requests to amend should be denied."[14]

Interested Party and Interested Person Comments

Interested Party, County of Santa Cruz

A supplemental filing was submitted by Glenn Kulm, Director of Administration for the Health Services Agency for the County of Santa Cruz on February 22, 2002. In his declaration, Mr. Kulm states:

> It is only the SEP [special education pupils] children who have an entitlement to services under AB 3632, which is the subject of this claim.
>
> Prior to the enactment of realignment…[b]oth local assistance funds and the SEP categorical funds contained a provision for a 10% match.
>
> After realignment, funds appropriated by the Department of Mental Health for SEP students contain a 10% match requirement under Welfare and Institutions Code Section 5712.
>
> We believe that if the Legislature had intended local assistance funds to be used for funding services to SEP children, there [sic]would not have created a separate and distinct funding category for these services.[15]

Interested Person, Catherine Camp

On February 15, 2002, a supplemental filing was submitted by Catherine Camp, former Executive Director of the California Mental Health Directors' Association. In her declaration, Ms. Camp states:

> To have included AB 3632 in the drafting of realignment would have required the legislature to make a decision as to whether it agreed with the state or counties on whether the program was a reimbursable mandate; to preclude the legislature having to side with either the state or local government, AB 3632 was excluded from realignment.[16]

STAFF ANALYSIS

Issue 1: What is the scope of jurisdiction and period of reimbursement for this request?

Government Code section 17557, subdivision (d), authorizes the Commission to amend the parameters and guidelines on request by a local agency. That section provides in relevant part the following:

> A local agency, school district, or the state may file a written request with the commission to amend, modify, or supplement the parameters and guidelines. The commission may, after public notice and hearing, amend,

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[14] Final Comments filed by SCO, attached in exhibit M.

[15] Supplemental Filing by County of Santa Cruz, attached in Exhibit M.

[16] Supplemental Filing by Catherine Camp, attached in Exhibit M.

> modify, or supplement the parameters and guidelines…. A parameters and guidelines amendment filed more than 90 days after the claiming deadline for initial claims, as specified in the claiming instructions pursuant to Section 17561, and on or before January 15 following a fiscal year, shall establish reimbursement eligibility for that fiscal year.[17]

The requests to amend the parameters and guidelines for *Handicapped and Disabled Students* (CSM 4282) were filed in June 2001. Thus, pursuant to Government Code section 17557, the period of reimbursement for any amendments adopted by the Commission pursuant to these requests would begin on July 1, 2000.

In addition, an amendment to the parameters and guidelines must be consistent with the Statement of Decision adopted by the Commission. Government Code section 17557, subdivision (a), states that if the Commission determines there are costs mandated by the state following a hearing on a test claim, it shall determine the amount to be subvened. In so doing, the Commission shall adopt parameters and guidelines for reimbursement of any claims relating to the statute or executive order approved by the Commission in the test claim. The Commission's regulations require that the parameters and guidelines describe "the most reasonable methods of complying with the mandate." The phrase, "the most reasonable methods of complying with the mandate," is defined as "those methods not specified in statute or executive order that are necessary to carry out the mandated program."[18] Thus, while the parameters and guidelines may define activities not spelled out in the Statement of Decision, those activities must be reasonably necessary to comply with the mandate and must relate to a finding by the Commission in the Statement of Decision on *Handicapped and Disabled Students* (CSM 4282).

Moreover, the Commission does not have jurisdiction, for purposes of the counties' request to amend the parameters and guidelines, to modify any findings made by the Commission in the original Statement of Decision on *Handicapped and Disabled Students* (CSM 4282). It is a well-settled issue of law that an administrative agency may not change a determination once its decision has become final absent express statutory authority or a court order.[19] Although the Legislature expressly directed the Commission to reconsider the Statement of Decision in *Handicapped and Disabled Students* (Stats. 2004, ch. 493 (SB1895)), the Commission's findings on reconsideration are prospective and have a reimbursement period beginning July 1, 2004.[20] Thus, the Commission's findings on reconsideration that the original Statement of Decision did not

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[17] Government Code section 17557 was amended in 2004 to add this language. (Stats. 2004, ch. 313 (A.B. 2224); Stats. 2004, ch. 890 (A.B. 2856), eff. Jan. 1, 2005.) However, at the time these requests were filed in June 2001, section 1183.2 of the Commission's regulations contained the same language.

[18] California Code of Regulations, title 2, section 1183.1, subdivision (a)(4), as amended September 6, 2005.

[19] *Olive Proration etc. Com. v. Agri. Etc. Com.* (1941) 17 Cal.2d 204, 209; *Save Oxnard Shores v. California Coastal Commission* (1986) 179 Cal.App.3d 140, 150.

[20] See Statement of Decision on the Reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10). (Exhibit H.)

fully identify all of the activities mandated by the test claim legislation apply only to reimbursement claims filed for the 2004-2005 fiscal year.

Finally, the Commission's findings in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), which approved as a reimbursable state-mandated program some of the amendments to the Handicapped and Disabled Students program from 1986 to 2002, cannot be applied retroactively to the original parameters and guidelines. Based on Government Code section 17557, subdivision (e), the reimbursement period for the activities approved by the Commission in *Handicapped and Disabled II* begins July 1, 2001.

Given these general principles, the counties' proposed amendments are analyzed below with respect to the relevant period of reimbursement (July 1, 2000, through June 30, 2004).

Issue 2: Should all references to the Short-Doyle Act and the 90/10 cost-sharing formula be deleted from the parameters and guidelines in *Handicapped and Disabled Students* (CSM 4282)?

The counties request that all references to the Short-Doyle cost-sharing mechanism for providing psychotherapy or other mental health treatment services be deleted from the parameters and guidelines. The counties contend that the Short-Doyle Act was repealed on July 1, 1991, and, thus, counties are entitled to 100 percent reimbursement for providing psychotherapy or other mental health treatment services. The counties also rely on Statutes 2002, chapter 1167 (AB 2781), which directed the State Controller's Office to not dispute reimbursement claims, filed in fiscal years up to and including the 2000-2001 fiscal year, with respect to the percentage of reimbursement the county claimed for allowable mental health treatment services.

For the reasons below, staff finds that the proposed amendment to delete all references to the Short-Doyle cost sharing mechanism is inconsistent with, and not supported by the Commission's Statement of Decision in *Handicapped and Disabled Students* (CSM 4282).

The Commission's Statement of Decision in *Handicapped and Disabled Students* (CSM 4282) contains a finding that the costs incurred for providing psychotherapy or other mental health treatment services were subject to the Short-Doyle Act. Under the Short-Doyle Act, the state paid 90 percent of the total costs of mental health treatment services and the counties paid the remaining 10 percent. Thus, the Commission concluded that counties incurred increased costs mandated by the state in an amount that equaled 10 percent of the total psychotherapy or other mental health treatment costs.

The Commission's original finding regarding the Short-Doyle Act was supported by the law in effect at the time the Statement of Decision was adopted in 1990. The test claim legislation (Stats. 1985, ch. 1274) amended Welfare and Institutions Code section 5651 to require that the annual Short-Doyle plan for each county include a description of the services required by Government Code sections 7571 and 7576 (psychotherapy or other mental health treatment services), including the cost of the services. Section 60200 of the joint regulations adopted by the Departments of Mental Health and Education required the county to be financially responsible for the provision of mental health treatment

services. The regulations further stated that reimbursement to the provider of the services shall be based on a negotiated net amount or rate approved by the Director of Mental Health as provided in Welfare and Institutions Code section 5705.2, or the provider's reasonable actual cost. Welfare and Institutions Code section 5705.2 imposed a cost-sharing ratio for mental health treatment services between the state and the counties, with the state paying 90 percent and the counties paying 10 percent of the total costs.

In 1993, the Sixth District Court of Appeal, in *County of Santa Clara v. Commission on State Mandates,* upheld the Commission's finding that psychotherapy or other mental health treatment services were to be funded as part of the Short-Doyle Act and, thus, only 10 percent of the total costs for treatment were reimbursable under article XIII B, section 6. The court interpreted the test claim legislation as follows:

> County entered into an NNA [negotiated net amount] contract with the state in lieu of the Short-Doyle plan and budget. (Welf. & Inst. Code, § 5705.2.) The NNA contract covers mental health services in the contracting county. The amount of money the state provides is the same whether the county signs a NNA contract or adopts a Short-Doyle plan…. By adding subdivision (g) to Welfare and Institutions Code section 5651, the legislature designated that the mental health services provided pursuant to Government Code section 7570 et seq. were to be funded as part of the Short-Doyle program. County's NNA contract was consistent with this intent. Accordingly, the fact that County entered into an NNA contract rather than a Short-Doyle plan and budget is not relevant.[21]

Based on these findings, the court concluded that only 10 percent of the costs were "costs mandated by the state" and, thus, reimbursable under article XIII B, section 6. The court held as follows:

> By placing these services within Short-Doyle, however, the legislature limited the extent of its mandate for these services to the funds provided through the Short-Doyle program. A Short-Doyle agreement or NNA contract sets the maximum obligation incurred by a county for providing the services listed in the agreement or contract. "Counties may <u>elect</u> to appropriate more than their 10 per cent share, but in no event can they be <u>required</u> to do so." (*County of Sacramento v. Loeb* (1984) 160 Cal.App.3d 446, 450.) Since the services were subject to the Short-Doyle formula under which the state provided 90 per cent of the funds and the county 10 per cent, that 10 per cent was reimbursable under section 6, article XIII B of the California Constitution. (Emphasis in original.)[22]

[21] Exhibit E, page 173.

[22] Exhibit E, page 173.

Thus, the Statement of Decision in *Handicapped and Disabled Students* (CSM 4282), which was affirmed by the Court of Appeal, is a final decision and cannot be changed without an express statutory provision or court order.

The parties are correct that there have been *subsequent changes* in the law, which are described below, that affect the reimbursement of costs for providing psychotherapy or other mental health treatment services. The Commission addressed these subsequent changes in the reconsideration of the original decision that was directed by the Legislature in *Handicapped and Disabled Students* (04-RL-4282-10) and in the subsequent test claim filed by the parties in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49).

In 1991, the Legislature enacted realignment legislation that repealed the Short-Doyle Act and replaced the sections with the Bronzan-McCorquodale Act. (Stats. 1991, ch. 89, §§ 63 and 173.) The realignment legislation became effective on June 30, 1991. The parties have disputed whether the Bronzan-McCorquodale Act keeps the cost-sharing ratio, with the state paying 90 percent and the counties paying 10 percent, for the cost of psychotherapy or other mental health treatment services for special education pupils.

In 2002, the Legislature enacted Statutes 2002, chapter 1167 (AB 2781). Section 41 of the bill directs the State Controller's Office to not dispute reimbursement claims, filed in fiscal years up to and including the 2000-2001 fiscal year, with respect to the percentage of reimbursement the county claimed for allowable mental health treatment services. This direction applies only to reimbursement claims filed by counties claiming 100 percent of their total costs for allowable mental health treatment services to special education pupils. The bill does not allow counties that claimed reimbursement for less than 100 percent to amend their claims. Section 41 of Statutes 2002, chapter 1167, states the following:

> Notwithstanding any other provision of law, with respect to the handicapped and disabled students state-mandated program, county reimbursement claims submitted to the Controller for reimbursement for services associated with providing, pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, allowable mental health treatment services required by an individualized education program in fiscal years up to and including 2000-01 fiscal year are not subject to dispute by the Controller's office regarding the percentage of reimbursement claimed by any county. A county that previously submitted a reimbursement claim for services delivered in the 2000-01 fiscal year or prior for less than 100 percent of the allowable mental health treatment services to special education pupils may not amend its claim for 100 percent or other percentage of those same allowable costs. This paragraph does not abridge the right of the Controller to otherwise dispute claims on the basis of allowable costs. With the exception of those costs claimed in excess of what is allowable, claims shall be fully paid at the percentage originally submitted.

Section 38 of Assembly Bill 2781 (Stats. 2002, ch. 1167) further provides that counties are not required to provide any share of costs from realignment funds for psychotherapy

or other mental health treatment services delivered under this program in fiscal year 2001-2002 and thereafter to special education pupils. Section 38 states in relevant part the following:

> For reimbursement claims for services delivered in the 2001-02 fiscal year and thereafter, counties are not required to provide any share of those costs or to fund the cost of any part of these services with money received from the Local Revenue Fund [i.e. realignment funds].

Finally, in 2004, the Legislature enacted Senate Bill 1895 (Stats. 2004, chapter 496, § 6) to provide that realignment funds under the Bronzan-McCorquodale Act that are used by a county for the *Handicapped and Disabled Students* program are not required to be deducted from the costs claimed for the program. Section 6 of Senate Bill 1895 adds, as part of the Bronzan-McCorquodale Act, section 5701.6 to the Welfare and Institutions Code, which states in relevant part the following:

> Counties may utilize money received from the Local Revenue Fund [realignment] …to fund the costs of any part of those services provided pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code. *If money from the Local Revenue Fund is used by counties for those services, counties are eligible for reimbursement from the state for all allowable costs* to fund assessments, psychotherapy, and other mental health services allowable pursuant to Section 300.24 of Title 34 of the Code of Federal Regulations [IDEA] and required by Chapter 26.5 … of the Government Code. (Emphasis added.)

Welfare and Institutions Code section 5701.6, subdivision (b), further states that "[t]his section is declaratory of existing law."

In both the reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10) and *Handicapped and Disabled II* (02-TC-40/02-TC-49), the Commission concluded, pursuant to Statutes 2002, chapter 1167 (AB 2781) and Statutes 2004, chapter 493 (SB 1895), that beginning July 1, 2001, the 90 percent-10-percent cost sharing ratio for the costs incurred for psychotherapy and other mental health treatment services no longer applies.[23] The Commission further concluded, pursuant to Statutes 2004, chapter 493 (SB 1895), that realignment funds are not required to be identified as an offset and deducted from the costs claimed for fiscal years 2001-2002 and thereafter.[24] These decisions have a reimbursement period beginning July 1, 2004 and July 1, 2001, respectively.

But the Commission's findings on the subsequent legislative changes in the law cannot be applied retroactively to the original parameters and guidelines in *Handicapped and Disabled Students* (CSM 4282), as requested by the counties. Neither Government Code section 17557, nor any other provision in the Government Code, grants the authority,

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[23] Exhibit H, Statement of Decision, 04-RL-4282-10; Exhibit J, Statement of Decision, 02-TC-40/02-tC-49.

[24] *Ibid*.

when determining a request to amend the parameters and guidelines, to change the findings made by the Commission in the Statement of Decision to reflect subsequent changes in the law.

Therefore, the proposed amendment to delete all references to the Short-Doyle cost sharing mechanism is inconsistent with, and not supported by the Commission's Statement of Decision in *Handicapped and Disabled Students* (CSM 4282).

Issue 3: Should the Commission add a provision to the parameters and guidelines in *Handicapped and Disabled Students* (CSM 4282) to reimburse counties for 60 percent of the residential board and care costs for in-state placement of seriously emotionally disturbed pupils in residential facilities?

The counties request that the Commission amend the parameters and guidelines in *Handicapped and Disabled Students* (CSM 4282) by adding a provision to reimburse counties for 60 percent of the residential board and care costs for in-state placement of pupils in residential facilities. The counties contend that the joint regulations adopted by the Departments of Mental Health and Education require counties to provide assessment, treatment, case management and residential care services, including room, board, care and supervision. The counties request that the following language be added to the parameters and guidelines:

> For each eligible claimant, residential services are reimbursable, when delineated in an IEP, in accordance with California Administrative Code, Title 2, Section 60100, including the "board and care" or "care and supervision" portion of residential services, in excess of the Department of Social Services (DSS) forty (40) percent share of DSS allowable room and board payments. As noted in California Administrative Code, Title 2, Section 60025, entitled "Social Services Definitions," subsection (a) states: "'Care and supervision" as defined in Welfare and Institutions Code Section 11460, includes food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation.'"

The Statement of Decision in *Handicapped and Disabled Students* (CSM 4282) contains a finding that "Government Code section 7572.5, subdivision (c), designates, for the first time that the local mental health program shall act as the lead case manager when the IEP prescribes residential placement for an 'individual with exceptional needs' who is "seriously emotionally disturbed.'"[25] Although the Statement of Decision authorizes reimbursement for the activities of the lead case manager for pupils that are placed in residential care, there is no finding in the Statement of Decision authorizing reimbursement for the costs of residential placement, or board and care of the pupil.

When the Commission reconsidered *Handicapped and Disabled Students* (04-RL-4282-10), the Commission concluded that counties were required to issue

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[25] Exhibit M, Statement of Decision, CSM 4282, page 423.

payments to providers of out-of-home residential facilities for the residential and non-educational costs of seriously emotionally disturbed pupils, and were entitled to reimbursement for 60 percent of the costs. The Commission's Statement of Decision on the reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10) approved the following activity for reimbursement:

> Issue payments to providers of out-of-home residential care for the residential and non-educational costs of seriously emotionally disturbed pupils (Gov. Code, § 7581; Cal. Code Regs., tit. 2, § 60200, subd. (e))
>
> - Issue payments to providers of out-of-home residential facilities for the residential and non-educational costs of seriously emotionally disturbed pupils. Payments are for the costs of food, clothing, shelter, daily supervision, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation. Counties are eligible to [sic] reimbursed for 60 percent of the total residential and non-educational costs of a seriously emotionally disturbed child placed in an out-of-home residential facility.[26]

However, the reimbursement period for the Statement of Decision on reconsideration begins July 1, 2004, and cannot be retroactively applied here. The Commission does not have jurisdiction, for purposes of the counties' request to amend the parameters and guidelines, to add to the findings made by the Commission in the original Statement of Decision on *Handicapped and Disabled Students* (CSM 4282). It is a well-settled issue of law that an administrative agency may not change a determination once its decision has become final absent express statutory authority or a court order.[27] Although the Legislature expressly directed the Commission to reconsider the Statement of Decision in *Handicapped and Disabled Students* (Stats. 2004, ch. 493 (SB1895)), the Commission's findings on reconsideration are prospective and have a reimbursement period beginning July 1, 2004.[28]

Therefore, the proposed amendment to add a cost provision to reimburse counties for 60 percent of the residential board and care costs for in-state placement of pupils in residential facilities is inconsistent with, and not supported by the Commission's Statement of Decision in *Handicapped and Disabled Students* (CSM 4282).

Issue 4: Should the Commission amend the provision authorizing reimbursement for mental health services in accordance with current law to include reimbursement for medication monitoring and crisis intervention?

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[26] Exhibit H, Statement of Decision on the Reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10).

[27] *Olive Proration etc. Com. v. Agri. Etc. Com*. (1941) 17 Cal.2d 204, 209; *Save Oxnard Shores v. California Coastal Commission* (1986) 179 Cal.App.3d 140, 150.

[28] Exhibit H, Statement of Decision on the Reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10).

The counties request that the Commission amend the provision in the parameters and guidelines for mental health services to include the current regulatory definition of "mental health services," medication monitoring, and crisis intervention. The counties request the following language be added to the parameters and guidelines:

> For each eligible claimant, the following cost items, for the provision of services when required by a child's individualized education program in accordance with Section 7572(d) of the Government Code: psychotherapy (including outpatient crisis-intervention psychotherapy provided in the normal course of IEP services when a pupil exhibits acute psychiatric symptoms, which, if untreated, presents an imminent threat to the pupil) as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management are reimbursable (Government Code 7576). "Medication monitoring" includes medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness.[29]

The counties' proposed language, however, is based on regulations amended by the Departments of Mental Health and Education effective July 1, 1998. (Cal. Code Regs., tit. 2, § 60020, subds. (i) and (f).) The 1998 regulations were considered by the Commission in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), and approved for the following activities beginning July 1, 2001:

- Provide individual or group psychotherapy services, as defined in Business and Professions Code section 2903, when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
- Provide medication monitoring services when required by the pupil's IEP. "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subds. (f) and (i).)

The Commission's findings in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), approving reimbursement for medication monitoring and psychotherapy services as currently defined in the regulations were not included in the original test claim (CSM 4282) and, thus, cannot be applied retroactively to the original parameters and guidelines. Based on Government Code section 17557, subdivision (e),

[29] Exhibit A, consolidated request to amend Parameters and Guidelines, page 111.

the reimbursement period for the activities approved by the Commission in *Handicapped and Disabled II* begins July 1, 2001.

Therefore, the proposed amendment to add language based on the current definition of "mental health services," including medication monitoring, is inconsistent with, and not supported by the Commission's original 1990 Statement of Decision in *Handicapped and Disabled Students* (CSM 4282).

Finally, the request to add crisis intervention as a reimbursable state-mandated activity must be denied since crisis intervention was deleted from the definition of mental health services before the potential reimbursement period for this request to amend the parameters and guidelines (July 1, 2000). The activity of crisis intervention was deleted from the regulations, effective July 1, 1998. (Cal. Code Regs., tit. 2, § 60020.) Thus, crisis intervention is not a state-mandated activity for the time period relevant to this request.

Issue 5: Should the Commission amend Section VI of the parameters and guidelines on Claim Preparation to add a paragraph regarding the reimbursement of indirect costs to comply with previously adopted boilerplate language?

The counties request that section VI of the parameters and guidelines, Claim Preparation, be amended to add the following paragraph regarding indirect costs for both the actual cost method and the cost report method (based on annual cost reports filed with the Department of Mental Health):

> Indirect costs are those that have been incurred for common or joint purposes. These costs benefit more than one cost objective and cannot be readily identified with a particular final cost objective without effort disproportionate to the results achieved. After direct costs have been determined and assigned to other activities, as appropriate, indirect costs are those remaining to be allocated to benefited cost objectives. A cost may not be allocated as an indirect cost if any other cost incurred for the same purpose, in like circumstances, has been claimed as a direct cost.
>
> Indirect costs include (a) the indirect costs originating in each department or agency of the governmental unit carrying out state mandated programs and (b) the costs of central governmental services distributed through the central service cost allocation plan and not otherwise treated as direct costs.

On October 25, 2006, the State Controller's Office requested an opportunity to file additional comments. The Controller's request stated in relevant part the following:

> Item 14 [of the October 26, 2006 hearing calendar] clarified indirect costs and offsetting revenues, and allows claimants to file amended claims from July 1, 2000, through June 30, 2004. Based on recent comments we have received from counties as to the impact the changes have on prior claims, we believe that additional time is needed to fully evaluate the proposed changes.

The Controller's request was approved for good cause. On November 6, 2006, the Controller filed additional comments recommending that the Commission deny the counties' requests to amend the language regarding the reimbursement of indirect costs. The Controller states in relevant part the following:

> The proposed amendment, effective for the reimbursement period of July 1, 2000 through June 30, 2004, includes the OMB Circular A-87 boilerplate language for indirect costs. The amendment does not add a new claiming activity nor expand indirect costs that are eligible for reimbursement. Furthermore, the proposed amendment does not identify any additional costs that could not have been claimed previously.

Staff recommends that the Commission deny the counties' request to amend section VI of the parameters and guidelines. Although the language proposed by the counties is consistent with boilerplate language adopted by the Commission in other parameters and guidelines, staff agrees that the language does not identify any additional costs that could not have been previously claimed by counties. Thus, it is not necessary to amend section VI, Claim Preparation.

Issue 6: Should the Commission amend the offset paragraph to include revenue received through Medi-cal, private pay insurance, state categorical funding (Item 4440-131-0001 of the State Budget Act), Healthy Families Program, and federal IDEA funding to be provided to backfill loss of state funding for the program?

Section VIII of the parameters and guidelines (Offsetting Savings and Other Reimbursements) currently states the following:

> A. Any offsetting savings the claimant experiences as direct result of this statute must be deducted from the costs claimed.
>
> B. The following reimbursements for this mandate shall be deducted from the claim:
>
> > 1. Any direct payments (categorical funding) received from the State which are specifically allocated to this program; and
> >
> > 2. Any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g., federal, state, etc.

The counties request that the offset paragraph of the parameters and guidelines be amended to specifically identify revenue received through Medi-cal, private pay insurance, state categorical funding (Item 4440-131-0001 of the State Budget Act), Healthy Families Program, and federal IDEA funding as offsets.

The State Controller's Office recommends that the counties' request to amend section VIII be denied as follows:

> The proposed amendment, effective for the reimbursement period of July 1, 2000 through June 30, 2004, replaces the Offsetting Savings and Other Reimbursements language with current boilerplate language and

> clarifies offsetting revenue and other reimbursements. The proposed amendment does not increase reimbursable costs.

When the Commission reconsidered the original test claim, the Commission found that the offset language in the parameters and guidelines did not properly identify the offsetting revenue that must be deducted from the costs claimed. The Commission made the following findings on reconsideration:

> The Commission agrees with the identification of any direct payments or categorical funds appropriated by the Legislature specifically for this program as an offset to be deducted from the costs claimed. In the past, categorical funding has been provided by the state for this program in the amount of $12.3 million.[30] The categorical funding was eliminated, however, in the Budget Acts of 2002 through 2004.
>
> If, however, funds are appropriated in the Budget Act for this program, such as the $69 million appropriation in the 2004-05 Budget Act, such funds are required to be identified as an offset.
>
> The Commission disagrees with the language in the existing parameters and guidelines that excludes private insurance payments as offsetting revenue. Federal law authorizes public agencies to access private insurance proceeds for services provided under the IDEA if the parent consents.[31] Thus, to the extent counties obtain private insurance proceeds with the consent of a parent for purposes of this program, such proceeds must be identified as an offset and deducted from the costs claimed. This finding is consistent with the California Supreme Court's decision in *County of Fresno v. State of California*. In the *County of Fresno* case, the court clarified that article XIII B, section 6 requires reimbursement by the state only for those expenses that are recoverable from tax revenues. Reimbursable costs under article XIII B, section 6, do not include reimbursement received from other non-tax sources.[32]
>
> The Commission further disagrees with the language in the existing parameters and guidelines that excludes Medi-Cal payments as offsetting revenue. Federal law authorizes public agencies, with certain limitations, to use public insurance benefits, such as Medi-Cal, to provide or pay for services required under the IDEA.[33] Federal law limits this authority as follows:
>
>> (2) With regard to services required to provide FAPE [free appropriate public education] to an eligible child under this part, the public agency-

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[30] Budget Acts of 1994-2001, Item 4440-131-0001.

[31] 34 Code of Federal Regulations section 300.142, subdivision (f).

[32] *County of Fresno v. State of California* (1991) 53 Cal.3d 482, 487.

[33] 34 Code of Federal Regulations section 300.142, subdivision (e).

(i) May not require parents to sign up for or enroll in public insurance programs in order for their child to receive FAPE under Part B of the Act;

(ii) May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but pursuant to paragraph (g)(2) of this section, may pay the cost that the parent would be required to pay;

(iii) May not use a child's benefits under a public insurance program if that use would

(A) Decrease available lifetime coverage or any other insured benefit;

(B) Result in the family paying for services that would otherwise be covered by the public insurance program and that are required for the child outside of the time the child is in school;

(C) Increase premiums or lead to the discrimination of insurance; or

(D) Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.[34]

According to the 2004 report published by Stanford Law School, 51.8 percent of the students receiving services under the test claim legislation are Medi-Cal eligible.[35] Thus, the Commission finds to the extent counties obtain proceeds under the Medi-Cal program from either the state or federal government for purposes of this mandated program, such proceeds must be identified as an offset and deducted from the costs claimed.

In addition, Government Code section 7576.5 describes offsetting revenue to counties transferred from local educational agencies for this program as follows:

> If funds are appropriated to local educational agencies to support the costs of providing services pursuant to this chapter, the local educational agencies shall transfer those funds to the community mental health services that provide services pursuant to this chapter in order to reduce the local costs of providing these services. These funds shall be used exclusively for programs operated under this

---

[34] 34 Code of Federal Regulations section 300.142, subdivision (e)(2).

[35] "Challenge and Opportunity – An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California," Youth and Education Law Clinic, Stanford Law School, May 2004, page 20.

> chapter and are offsetting revenues in any reimbursable mandate claim relating to special education programs and services.
>
> Government Code section 7576.5 was added by the Legislature in 2003 (Stats. 2003, ch. 227) and became operative and effective on August 11, 2003. Thus, the Commission finds money received by counties pursuant to Government Code section 7576.5 shall be identified as an offset and deducted from the costs claimed.[36]

Staff finds that the offsetting revenue described above also applies to reimbursement claims filed for the period of July 1, 2000, through and including June 30, 2004, and, thus, should be identified as offsets pursuant to this request.

In addition, when the Commission adopted the parameters and guidelines on reconsideration, the Commission identified a $69 million appropriation made to counties for this program by Statutes 2003, chapter 157, item 6110-161-0890, provision 17.[37] This appropriation also applies to the claims filed for the period of July 1, 2000, through and including June 30, 2004, and should be identified as an offset.

Thus, staff recommends that the offset paragraph of the parameters and guidelines in *Handicapped and Disabled Students* (CSM 4282) be amended, consistent with its past findings, to state the following:

> Any offsetting revenues and reimbursements the claimant experiences in the same program as a result of the same statutes or executive orders found to contain the mandate shall be deducted from the costs claimed. In addition, reimbursement for this mandate received from any of the following sources shall be identified and deducted from this claim:
>
> 1. Funds received by a county pursuant to Government Code section 7576.5 (operative and effective on August 11, 2003).
> 2. Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes the appropriation made by the Legislature in the Budget Acts of 2000 and 2001, which appropriated funds to counties in the amount of $12,334,000 (Stats. 2000, ch. 52, item 4440-131-0001; Stats. 2001, ch. 106, item 4440-131-0001), and the $69 million appropriation in 2003 (Stats. 2003, ch. 157, item 6110-161-0890, provision 17).
> 3. Private insurance proceeds obtained with the consent of a parent for purposes of this program.
> 4. Medi-Cal proceeds obtained from the state or federal government, exclusive of the county match, that pay for a portion of the county services provided to a pupil

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[36] Exhibit H, Statement of Decision, Reconsideration of Handicapped and Disabled Students (04-RL-4282-10).

[37] Exhibit I, Parameters and guidelines, *Reconsideration of Handicapped and Disabled Students* (04-RL-4282-10).

under the Handicapped and Disabled Students program in accordance with federal law.

5. Any other reimbursement received from the federal or state government, or other non-local source.[38]

In addition, staff recommends that the title of Section VIII, currently identified as "Offsetting Savings and Other Reimbursements," be changed to "Offsetting Revenues and Reimbursements." This change is recommended to conform to the language of section 1183.1, subdivision (a)(7), of the Commission's regulations, as amended on September 6, 2005.

CONCLUSION

Staff recommends that the Commission adopt the staff analysis and the proposed parameters and guidelines, as modified by staff, which begins on page 33, to incorporate the language regarding offsetting revenue. The proposed amendments are effective for the reimbursement period beginning July 1, 2000, through and including June 30, 2004.

Staff further recommends that the Commission authorize staff to make any non-substantive, technical corrections to the parameters and guidelines following the hearing.

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[38] Section 1183.1, subdivision (a)(7), requires the identification of offsetting revenues and reimbursements in the parameters and guidelines.

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Adopted: August 22, 1991
Amended: August 29, 1996
Amended: January 26, 2006
Proposed Amendment: _____
j:mandates/2000statutes/PGA/PGA-03/04/DSA Dec2006

PROPOSED AMENDMENT TO PARAMETERS AND GUIDELINES

As Modified By Staff

Government Code Sections 7570-7588

Statutes 1984, Chapter 1747 (Assem. Bill No. 3632);
Statutes 1985, Chapter 1274 (Assem. Bill No. 882)

California Code of Regulations, Title 2, Sections 60000-60610 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28))

Handicapped and Disabled Students (CSM 4282)
July 1, 2000 – June 30, 2004

I. SUMMARY OF MANDATE

Chapter 1747 of the Statutes of 1984 added Chapter 26, commencing with section 7570, to Division 7 of Title 1 of the Government code (Gov. Code).

Chapter 1274 of the Statutes of 1985 amended sections 7572, 7572.5, 7575, 7576, 7579, 7582, and 7587 of, amended and repealed 7583 of, added section 7586.5 and 7586.7 to, and repealed 7574 of, the Gov. Code, and amended section 5651 of the Welfare and Institutions Code.

To the extent that Gov. Code section 7572 and section 60040, Title 2, Code of California Regulations, require county participation in the mental health assessment for "individuals with exceptional needs," such legislation and regulations impose a new program or higher level of service upon a county. Furthermore, any related county participation on the expanded "Individualized Education Program" (IEP) team and case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed," pursuant to subdivisions (a), (b), and (c) of Gov. Code section 7572.5 and their implementing regulations, impose a new program or higher level of service upon a county.

The aforementioned mandatory county participation in the IEP process is not subject to the Short-Doyle Act, and accordingly, such costs related thereto are costs mandated by the state and are fully reimbursable within the meaning of section 6, article XIIIB of the California Constitution.

The provisions of Welfare and Institutions Code section 5651, subdivision (g), result in a higher level of service within the county Short-Doyle program because the mental health

services, pursuant to Gov. Code sections 7571 and 7576 and their implementing regulations, must be included in the county Short-Doyle annual plan. Such services include psychotherapy and other mental health services provided to "individuals with exceptional needs," including those designated as "seriously emotionally disturbed," and required in such individual's IEP.

Such mental health services are subject to the current cost sharing formula of the Short-Doyle Act, through which the state provides ninety (90) percent of the total costs of the Short-Doyle program, and the county is required to provide the remaining ten (10) percent of the funds. Accordingly, only ten (10) percent of such program costs are reimbursable within the meaning of section 6, article XIIIB of the California Constitution as costs mandated by the state, because the Short-Doyle Act currently provides counties ninety (90) percent of the costs of furnishing those mental health services set forth in Gov. Code section 7571 and 7576 and their implementing regulations, and described in the county's Short-Doyle annual plan pursuant to Welfare and Institutions Code section 5651, subdivision (g).

II. COMMISSION ON STATE MANDATES' DECISIONS

The Commission on State Mandates, at its April 26, 1990 hearing, adopted a Statement of Decision that determined that County participation in the IEP process is a state mandated program and any costs related thereto are fully reimbursable. Furthermore, any mental health treatment required by an IEP is subject to the Short-Doyle cost sharing formula. Consequently, only the county's Short-Doyle share (i.e., ten percent) of the mental health treatment costs will be reimbursed as costs mandated by the state.

Statutes 2004, chapter 493 (Sen. Bill No. 1895) directed the Commission to reconsider the 1990 Statement of Decision and parameters and guidelines for this program. On May 26, 2005, the Commission adopted a Statement of Decision on reconsideration of Handicapped and Disabled Students (04-RL-4282-10). The Commission found that the 1990 Statement of Decision correctly concluded that the test claim legislation imposes a reimbursable state-mandated program on counties pursuant to article XIII B, section 6 of the California Constitution. The Commission determined, however, that the 1990 Statement of Decision does not fully identify all of the activities mandated by the statutes and regulations pled in the test claim or the offsetting revenue applicable to the claim. Thus, the Commission, on reconsideration, identified the activities expressly required by the test claim legislation and the offsetting revenue that must be identified and deducted from the costs claimed. The Commission's Statement of Decision on reconsideration has a period of reimbursement beginning July 1, 2004.

III. ELIGIBLE CLAIMANTS

All counties

IV. PERIOD OF REIMBURSEMENT

Section 17557 of the Gov. Code states that a test claim must be submitted on or before December 31 following a given fiscal year to establish eligibility for that year. The test claim for this mandate was filed on August 17, 1987; all costs incurred on or after July 1, 1986, through and including June 30, 2004, are reimbursable.

This amended set of parameters and guidelines is operative for reimbursement claims filed for the period from July 1, 2000, through and including June 30, 2004.

Costs incurred beginning July 1, 2004, shall be claimed under the parameters and guidelines for the Commission's decision on reconsideration, *Handicapped and Disabled Students* (04-Rl-4282-10).

Actual costs for one fiscal year should be included in each claim, and estimated costs for the subsequent year may be included on the same claim, if applicable, pursuant to Government Code section 17561.

If the total costs for a given fiscal year do not exceed $200[39], no reimbursement shall be allowed, except as otherwise allowed by Gov. Code section 17564.

V. REIMBURSABLE COSTS

A. One Hundred (100) percent of any costs related to IEP Participation, Assessment, and Case Management:

1. The scope of the mandate is one hundred (100) percent reimbursement, except that for individuals billed to Medi-Cal only, the Federal Financing Participation portion (FFP) for these activities should be deducted from reimbursable activities not subject to the Short-Doyle Act.

2. For each eligible claimant, the following cost items are one hundred (100) percent reimbursable (Gov. Code, section 7572, subd. (d)(1)):

   a. Whenever an LEA refers an individual suspected of being an 'individual with exceptional needs' to the local mental health department, mental health assessment and recommendation by qualified mental health professionals in conformance with assessment procedures set forth in Article 2 (commencing with section 56320) of Chapter 4 of part 30 of Division 4 of the Education Code, and regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, including but not limited to the following mandated services:

      i. interview with the child and family,

      ii. collateral interviews, as necessary,

      iii. review of the records,

      iv. observation of the child at school, and

      v. psychological testing and/or psychiatric assessment, as necessary.

   b. Review and discussion of mental health assessment and recommendation with parent and appropriate IEP team members. (Government Code section 7572, subd. (d)(1)).

[39] Beginning September 30, 2002, claims must exceed $1000. (Stats. 2002, ch. 1124.)

c. Attendance by the mental health professional who conducted the assessment at IEP meetings, when requested. (Government Code section 7572, subd. (d)(1)).

d. Review by claimant's mental health professional of any independent assessment(s) submitted by the IEP team. (Government Code section 7572, subd. (d)(2)).

e. When the written mental health assessment report provided by the local mental health program determines that an 'individual with special needs' is 'seriously emotionally disturbed', and any member of the IEP team recommends residential placement based upon relevant assessment information, inclusion of the claimant's mental health professional on that individual's expanded IEP team.

f. When the IEP prescribes residential placement for an 'individual with exceptional needs' who is 'seriously emotionally disturbed,' claimant's mental health personnel's identification of out-of-home placement, case management, six month review of IEP, and expanded IEP responsibilities. (Government Code section 7572.5).

g. Required participation in due process procedures, including but not limited to due process hearings.

3. One hundred (100) percent of any administrative costs related to IEP Participation, Assessment, and Case Management, whether direct or indirect.

B. Ten (10) percent of any costs related to mental health treatment services rendered under the Short-Doyle Act:

1. The scope of the mandate is ten (10) percent reimbursement.

2. For each eligible claimant, the following cost items, for the provision of mental health services when required by a child's individualized education program, are ten (10) percent reimbursable (Government Code 7576):

   a. Individual therapy,

   b. Collateral therapy and contacts,

   c. Group therapy,

   d. Day treatment, and

   e. Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.

3. Ten (10) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

VI. CLAIM PREPARATION

There are two satisfactory methods of submitting claims for reimbursement of increased costs incurred to comply with the mandate:

A. Actual Increased Costs Method. To claim under the Actual Increased Costs Method, report actual increased costs incurred for each of the following expense

categories in the format specified by the State Controller's claiming instructions. Attach supporting schedules as necessary:

1. Employee Salaries and Benefits: Show the classification of the employees involved, mandated functions performed, number of hours devoted to the function, and hourly rates and benefits.

2. Services and supplies: Include only expenditures which can be identified as a direct cost resulting from the mandate. List cost of materials acquired which have been consumed or expended specifically for the purpose of this mandate.

3. Direct Administrative Costs:

   a. One hundred (100) percent of any direct administrative costs related to IEP Participation, Assessment, and Case Management.

   b. Ten (10) percent of any direct administrative costs related to mental health treatment rendered under the Short-Doyle Act.

4. Indirect Administrative and Overhead Costs: To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions:

   a. Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs which exceeds ten (10) percent of total program direct labor costs, excluding fringe benefits.

   OR if an indirect cost rate greater than ten (10) percent is being claimed,

   b. By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program; each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP(s).

B. Cost Report Method. Under this claiming method the mandate reimbursement claim is still submitted on the State Controller's claiming forms in accordance with the claiming instructions. A complete copy of the annual cost report including all supporting schedules attached to the cost report as filed with DMH must also be filed with the claim forms submitted to the State Controller.

   1. To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions:

a. Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs which exceeds ten (10) percent of total program direct labor costs, excluding fringe benefits.

OR if an indirect cost rate greater than ten (10) percent is being claimed,

b. By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program; each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP(s).

VII. SUPPORTING DATA

For auditing purposes, all costs claimed must be traceable to source documents and/or worksheets that show evidence of the validity of such costs. Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district is subject to audit by the State Controller no later than two years after the end of the calendar year in which the reimbursement claim is filed or last amended. However, if no funds are appropriated for the program for the fiscal year for which the claim is made, the time for the State Controller to initiate an audit shall commence to run from the date of initial payment of the claim.

VIII. OFFSETTING ~~SAVINGS AND OTHER REIMBURSEMENTS~~ REVENUES AND OTHER REIMBURSEMENTS

~~A. Any offsetting savings the claimant experiences as a direct result of this statute must be deducted from the costs claimed.~~

~~B. The following reimbursements for this mandate shall be deducted from the claim:~~

~~1. Any direct payments (categorical funding) received from the State which are specifically allocated to this program; and~~

~~2. Any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g. federal, state, etc.~~

Any offsets and reimbursements the claimant experiences in the same program as a result of the same statutes or executive orders found to contain the mandate shall be deducted from the costs claimed. In addition, reimbursement for this mandate received from any of the following sources shall be identified and deducted from this claim:

Deleted: ting revenues

1. Funds received by a county pursuant to Government Code section 7576.5 (operative and effective on August 11, 2003).

2. Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes the appropriation made by the Legislature in the Budget Acts of 2000 and 2001, which appropriated funds to counties in the amount of $12,334,000 (Stats. 2000, ch. 52, item 4440-131-0001; Stats. 2001, ch. 106, item 4440-131-0001), and the $69 million appropriation in 2003 (Stats. 2003, ch. 157, item 6110-161-0890, provision 17).
3. Private insurance proceeds obtained with the consent of a parent for purposes of this program.
4. Medi-Cal proceeds obtained from the state or federal government, exclusive of the county match, that pay for a portion of the county services provided to a pupil under the Handicapped and Disabled Students program in accordance with federal law.
5. Any other reimbursement received from the federal or state government, or other non-local source.

IX. REQUIRED CERTIFICATION

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An authorized representative of the claimant will be required to provide a certification of claim, as specified in the State Controller's claiming instructions, for those costs mandated by the state contained herein.

Supreme Court of California
Patrick O'RIORDAN, Plaintiff and Appellant,
v.
FEDERAL KEMPER LIFE ASSURANCE, Defendant and Appellant.

No. S115495.
July 7, 2005.

Background: Beneficiary of decedent's life insurance sued insurer, which had rescinded policy and denied beneficiary's claim on ground that insured had concealed her smoking of cigarettes in 36-month period preceding her application thereby obtaining "preferred nonsmoker rate." The Superior Court, Sacramento County, No. 99AS04726,Joe S. Gray, J., granted insurer summary judgment. Beneficiary appealed. The Court of Appeal affirmed, and the Supreme Court granted beneficiary's petition for review.

Holdings: The Supreme Court, Kennard, J., held that:
(1) material issue of fact remained whether insured concealed her smoking, and
(2) agent's knowledge of insured's smoking was imputed to insurer.

Judgment of the Court of Appeal reversed and matter remanded.

West Headnotes

[1] Appeal and Error 30 863

30 Appeal and Error
30XVI Review
30XVI(A) Scope, Standards, and Extent, in General
30k862 Extent of Review Dependent on Nature of Decision Appealed from
30k863 k. In General. Most Cited Cases

On a plaintiff's appeal from the trial court's grant of summary judgment against him, the Supreme Court must independently examine the record in order to determine whether triable issues of fact exist to reinstate the action.

[2] Appeal and Error 30 893(1)

30 Appeal and Error
30XVI Review
30XVI(F) Trial De Novo
30k892 Trial De Novo
30k893 Cases Triable in Appellate Court
30k893(1) k. In General. Most Cited Cases

Appeal and Error 30 895(2)

30 Appeal and Error
30XVI Review
30XVI(F) Trial De Novo
30k892 Trial De Novo
30k895 Scope of Inquiry
30k895(2) k. Effect of Findings Below. Most Cited Cases

In performing its de novo review of a summary judgment against a plaintiff, the Supreme Court views the evidence in the light most favorable to plaintiff and liberally construes plaintiff's evidence and strictly scrutinizes that of defendant in order to resolve any evidentiary doubts or ambiguities in plaintiff's favor.

[3] Insurance 217 3019

217 Insurance
217XXIV Avoidance
217XXIV(C) Special Circumstances Affecting Risk
217k3019 k. Habits. Most Cited Cases

When an applicant for life insurance misrepresents his or her history as a smoker in order to obtain a nonsmoker rate, the insurer may rescind the policy. West's Ann.Cal.Ins.Code §§ 330–332, 334, 359.

[4] Judgment 228 181(23)

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228 Judgment
228V On Motion or Summary Proceeding
228k181 Grounds for Summary Judgment
228k181(15) Particular Cases
228k181(23) k. Insurance Cases. Most Cited Cases

Material issue of fact remained whether insured under life insurance policy concealed her smoking to obtain "preferred nonsmoker rate," thus precluding summary judgment for insurer in insurance beneficiary's action against insurer which had rescinded policy after insured died; applicant, who had smoked one or two cigarettes in 36-month period preceding her application, answered "no" to two questions, the question "Have you smoked cigarettes in the past 36 months?" could reasonably be construed as meaning habitual smoking, and "Have you used tobacco in any other form in the past 36 months?" could be construed as referring to tobacco products other than cigarettes. West's Ann.Cal.Ins.Code §§ 330–332, 334, 359.

See 1 Witkin, Summary of Cal. Law (9th ed. 1987) Contracts, § 415A; Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2004) ¶ 15:921 et seq. (CAINSL Ch. 15-I); Cal. Jur. 3d, Insurance Contracts and Coverage, § 167 et seq.

[5] Insurance 217 ⚷1606

217 Insurance
217XI Agents and Agency
217XI(A) In General
217k1605 Agency for Insurer or Insured
217k1606 k. In General. Most Cited Cases

Insurance 217 ⚷1644

217 Insurance
217XI Agents and Agency
217XI(C) Agents for Insurers
217k1643 Duties and Liabilities of Agent to Insurer
217k1644 k. In General. Most Cited Cases

Insurance 217 ⚷3091

217 Insurance
217XXVI Estoppel and Waiver of Insurer's Defenses
217k3088 Knowledge or Notice of Facts in General
217k3091 k. Officers or Agents; Imputed Knowledge. Most Cited Cases

Independent agent's knowledge that life insurance applicant had smoked one or two cigarettes in 36-month period preceding application was imputed to insurer; agent became insurer's agent when he assisted applicant in responding to insurer's medical questionnaire, agent therefore had duty to disclose to insurer any material information regarding application, and insurer was deemed to have knowledge of such facts even though insured denied tobacco use in her application. West's Ann.Cal.Ins.Code §§ 330–332, 334, 359.

[6] Principal and Agent 308 ⚷177(1)

308 Principal and Agent
308III Rights and Liabilities as to Third Persons
308III(E) Notice to Agent
308k177 Imputation to Principal in General
308k177(1) k. In General. Most Cited Cases

Knowledge acquired by agent is imputed to the principal even when the knowledge was not actually communicated to the principal.

[7] Principal and Agent 308 ⚷179(2)

308 Principal and Agent
308III Rights and Liabilities as to Third Persons
308III(E) Notice to Agent
308k179 Time of Notice to Agent
308k179(2) k. Knowledge Acquired Previous to Agency. Most Cited Cases

A principal is charged with knowledge which his agent acquires before the commencement of the agency relationship when that knowledge can reasonably be said to be present in the mind of the agent while acting for the principal.

[8] Judgment 228 ⚷181(2)

228 Judgment
228V On Motion or Summary Proceeding
228k181 Grounds for Summary Judgment

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228k181(2) k. Absence of Issue of Fact. Most Cited Cases

When a dispositive factual issue is disputed, summary judgment is improper.

***508 Wohl Sammis Christian & Perkins, Wohl Sammis & Perkins, Alvin R. Wohl, Robin K. Perkins and Christopher F. Wohl, Sacramento, for Plaintiff and Appellant.

Sarrail, Lynch & Hall, Vogl & Meredith, Linda J. Lynch and David A. Firestone, San Francisco, for Defendant and Appellant.

KENNARD, J.

283 **754** After his wife's death from breast cancer, plaintiff, as beneficiary of his wife's life insurance policy, sought to collect the policy proceeds. Defendant insurance company, however, rescinded the policy and denied plaintiff's claim. It asserted that the wife had concealed from the insurer her smoking of cigarettes in the 36–**509** month period preceding her application, and that had she been truthful it would not have issued a policy at the "preferred nonsmoker rate." Plaintiff sued. The trial court granted the insurer's motion for summary judgment. We conclude that whether there was concealment is a disputed material fact, and therefore summary judgment was improper.

***284 I**

[1][2] Because plaintiff has appealed from the trial court's grant of summary judgment against him, we must "independently examine the record in order to determine whether triable issues of fact exist to reinstate the action." (*Wiener v. Southcoast Childcare Centers, Inc.* (2004) 32 Cal.4th 1138, 1142, 12 Cal.Rptr.3d 615, 88 P.3d 517; see also ****755***Saelzler v. Advanced Group 400* (2001) 25 Cal.4th 763, 767, 107 Cal.Rptr.2d 617, 23 P.3d 1143.) "In performing our de novo review, we view the evidence in the light most favorable to plaintiff[ ]" (*Wiener, supra,* at p. 1142, 12 Cal.Rptr.3d 615, 88 P.3d 517), and we "liberally construe" plaintiff's evidence and "strictly scrutinize" that of defendant "in order to resolve any evidentiary doubts or ambiguities in [plaintiff's] favor" (*ibid.*). Viewed in that light, these are the facts here:

In 1996, plaintiff Patrick O'Riordan and his wife Amy consulted Robert Hoyme, an independent insurance agent, for the purpose of replacing their life insurance policies with term life insurance. Hoyme suggested a policy issued by defendant Federal Kemper Life Assurance Company (Kemper). In the course of two meetings with Hoyme, the O'Riordans filled out application forms for Kemper policies at the preferred nonsmoker rate.

The insurance applications had a medical questionnaire, which asked these two questions: (1) "Have you smoked cigarettes in the past 36 months?," and (2) "Have you used tobacco in any other form in the past 36 months?" According to plaintiff, his wife, Amy, had smoked for many years but quit in 1991, five years before submitting her application. Amy told Hoyme that she had been a smoker and that her previous life insurance policy was a smokers' policy. She also mentioned that she "might have had a couple of cigarettes in the last couple of years." Hoyme replied: "That's not really what they're looking for. They're looking for smokers." He explained that the O'Riordans would have to undergo blood and urine tests to determine whether their bodies contained any traces of smoking. Someone—the record does not say whether it was Hoyme or Amy—checked the boxes marked "No" next to the two questions at issue. A doctor, approved and paid for by Kemper, examined Amy and took blood and urine samples, which showed no traces of nicotine.

Although Hoyme had been an independent agent for many years, he had not previously sold insurance for Kemper. He submitted a request to be appointed as Kemper's agent, along with the O'Riordans' policy application forms, to Cenco Insurance Marketing Corporation, a general agent for Kemper with authority to recruit agents. On May 24, 1996, two days after the ***285** O'Riordans had filled out their applications, Cenco approved Hoyme's request to be appointed a Kemper agent. On June 28, 1996, Kemper issued a term life insurance policy to Amy at the preferred nonsmoker rate, listing plaintiff as the beneficiary. Kemper paid Hoyme a monthly commission as its agent on the policy.

In November 1997, Amy was diagnosed with metastatic breast cancer. When Amy learned that she had only a short time to live, she began smoking again. She died *****510** on June 26, 1998, two days before the policy's two-year contestability period expired.

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When plaintiff sought to collect on Amy's life insurance policy, Kemper conducted an investigation and learned that in July 1995, less than a year before Amy applied for the policy, Amy had asked her physician for, and received, a nicotine patch. The physician's report stated that although Amy had quit smoking several years previously, "recently, due to some stressors, she did start to smoke a little bit again, but is not smoking as much as she smoked previously." Based primarily on this information, Kemper concluded that Amy had falsely answered the application's questions pertaining to her smoking. It denied plaintiff's claim, and it rescinded the policy it had issued to Amy.

Plaintiff then filed this action in superior court against Kemper, Cenco, and Hoyme. As amended, his complaint sought damages for breach of contract, breach of the covenant of good faith and fair dealing, negligence, fraud, negligent misrepresentation, and emotional distress. After plaintiff settled with Hoyme, the court, at plaintiff's request, dismissed the complaint against Cenco, leaving only Kemper as a defendant.

Kemper moved for summary judgment or summary adjudication, claiming the facts were undisputed that Amy falsely answered the application's questions about smoking and tobacco use in the 36 months preceding her application, thus entitling Kemper to rescind Amy's life insurance policy. Kemper added that had Amy told the truth it would not have issued the policy. In his response, ****756** plaintiff admitted that Amy had smoked a couple of cigarettes in 1995 but said that this was the full extent of her smoking in the 36–month period preceding her application, and that she had obtained the nicotine patch as a precautionary measure. Plaintiff asserted that Amy had accurately described her cigarette usage to Hoyme when she applied for the insurance policy. The trial court granted Kemper's motion and entered judgment for Kemper. Plaintiff appealed.

***286** In a two-to-one decision, the Court of Appeal affirmed the judgment. Justice Nicholson's lead opinion concluded that even if Amy had smoked only two cigarettes in the 36 months preceding her application, she concealed the extent of her cigarette usage because she answered "no" to the questions in the application pertaining to her cigarette and tobacco usage in that period. The lead opinion described Kemper's two questions about Amy's use of tobacco as "a term of the [insurance] contract," which unambiguously required Amy to answer "yes" to each question if she had smoked even one cigarette during the 36–month period at issue. Although the lead opinion concluded that insurance salesman Hoyme was Kemper's agent when he assisted Amy in answering those two questions, it reasoned that Hoyme's actual and ostensible authority "did not extend to interpreting an unambiguous term in the insurance."

Justice Blease concurred in the result, but on different grounds. In his view, based on the report of Amy's doctor who had given her the nicotine patch, Amy's smoking "was not confined to a couple of cigarettes but was a continuous problem...." Thus, he concluded, she "concealed the true extent of her smoking ... which justifies rescission of the policy...."

Justice Hull dissented. He concluded that Kemper was estopped from asserting any concealment by Amy of her cigarette use, because she did tell Hoyme, whom Justice Hull viewed as Kemper's agent, that she had smoked a couple of cigarettes in the two years before her application. *****511** Moreover, Justice Hull said, Hoyme had "the ostensible authority to advise Amy O'Riordan of the information the insurance company needed to decide whether to issue a nonsmoker's policy...."

We granted plaintiff's petition for review.

II

Under California law, every party to an insurance contract must "communicate to the other, in good faith, all facts within his knowledge which are ... material to the contract ... and which the other has not the means of ascertaining." (Ins.Code, § 332.) [FN1] "Materiality" is determined by "the probable and reasonable influence of the facts upon the party to whom the communication is due...." (§ 334.)

FN1. All statutory citations are to the Insurance Code unless otherwise stated.

[3] When an insured has engaged in "concealment," which is defined by statute as the "[n]eglect to communicate that which a party knows, and ought to communicate" (§ 330), the insurer may rescind the policy, even if the act ***287** of concealment was un-

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intentional (§ 331). Similarly, a materially false representation at the time of, or before, issuance of a policy may result in rescission of the policy. (§ 359.) Thus, when an applicant for life insurance misrepresents his or her history as a smoker in order to obtain a nonsmoker rate, the insurer may rescind the policy. (*Old Line Life Ins. Co. v. Superior Court* (1991) 229 Cal.App.3d 1600, 1603–1606, 281 Cal.Rptr. 15.)

[4] Kemper asserts that the facts are undisputed that Amy concealed the true extent of her cigarette use during the 36–month period preceding her application for life insurance. But plaintiff argues that Kemper is estopped from asserting any concealment by Amy because Hoyme, who plaintiff claims was Kemper's agent when he sold Amy the policy, told Amy she could answer "no" to Kemper's two questions inquiring into her smoking during the period at issue. Alternatively, plaintiff argues that Hoyme had ostensible authority to construe the meaning of the questions and that in advising Amy to respond "no" to the questions at issue, he misrepresented their meaning. (See ****757**6 Couch on Insurance (3d ed.1997) § 85:44, p. 85–67 ["If the insurer's agent construes the questions [in an insurance application] either by stating what they mean or by specifically stating that certain information is or is not required, any misrepresentations which result therefrom are charged to the insurer, the theory being that the insurer's agent remains the insurer's agent even though he or she is assisting the insured."]; see also 3 Appleman on Insurance 2d (Holmes ed.1998) § 10.4, p. 12.)

Here, we need not decide the merits of plaintiff's claims of estoppel and ostensible authority. As we will explain, regardless of how those questions are resolved, it is a triable issue of fact whether Amy concealed or failed to communicate material information to Kemper regarding her use of cigarettes in the 36 months preceding her application for life insurance at a nonsmoker rate. Therefore, the trial court erred in granting Kemper's summary judgment motion.

Pertinent are Amy's answers to the two questions in Kemper's medical questionnaire inquiring into her cigarette and tobacco usage. The first question asked, "Have you smoked cigarettes in the past 36 months?" That inquiry can reasonably be construed as an attempt to determine *habitual* use, not the smoking of a single cigarette or two during that entire period. Had Kemper intended disclosure of the *****512** latter, it could have inquired into the smoking of "any" cigarette during the relevant period. The second question asked: "Have you used tobacco *in any other form* in the past 36 months?" ***288** Italics added.) Because this question directly followed the question pertaining to *cigarette* use, an applicant could reasonably construe it as inquiring into use of tobacco in any form *other than cigarettes.* Therefore, an applicant who, like Amy, has smoked just a couple of cigarettes but has not used tobacco in any other form during the period at issue could correctly answer "no" to this question.

Thus, if (as plaintiff maintains) Amy smoked only a cigarette or two during the 36 months preceding her application and did not use any other tobacco products, she did not conceal her cigarette usage by answering "no" to the two questions at issue.

[5][6] Moreover, even if, as Kemper insists, those two questions required disclosure of even a single cigarette smoked during the period at issue, Amy did not conceal that information from Kemper, because she did mention it to Hoyme when she applied for the life insurance. Although Hoyme was not Kemper's agent when he assisted Amy in responding to Kemper's medical questionnaire, he became one when his request to be so appointed—submitted with Amy's application—was granted. (See generally Ins.Code, § 1704.5.) Once he became Kemper's agent, Hoyme had a duty to disclose to Kemper any material information he had pertaining to Amy's life insurance policy, and Kemper is deemed to have knowledge of such facts. (*In re Marriage of Cloney* (2001) 91 Cal.App.4th 429, 439, 110 Cal.Rptr.2d 615 ["As a general rule, an agent has a duty to disclose material matters to his or her principal, and the actual knowledge of the agent is imputed to the principal."]; Civ.Code, § 2332 ["As against a principal, both principal and agent are deemed to have notice of whatever either has notice of, and ought, in good faith and the exercise of ordinary care and diligence, to communicate to the other."].) Therefore, Hoyme's knowledge of Amy's smoking of one or two cigarettes during the 36 months preceding the application was imputed to Kemper. "The fact that the knowledge acquired by the agent was not actually communicated to the principal ... does not prevent operation of the rule." (*Columbia Pictures Corp. v. DeToth* (1948) 87 Cal.App.2d 620, 630, 197 P.2d 580.)

[7] Nor does it matter that Hoyme acquired the

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information regarding Amy's cigarette use before he became Kemper's agent. "The principal is charged with knowledge which his agent acquires before the commencement of the relationship when that knowledge can reasonably be said to be present in the mind of the agent while acting for the principal." (*Columbia Pictures Corp. v. DeToth, supra,* 87 Cal.App.2d at p. 631, 197 P.2d 580; see also *Schiffman v. Richfield Oil Co.* (1937) 8 Cal.2d 211, 220–221, 64 P.2d 1081; Rest.2d Agency, § 276.) Here, because Hoyme became Kemper's agent shortly after acquiring information about Amy's ****758** smoking, his knowledge of her smoking ***289** "can reasonably be said to be present in [his] mind" (*Columbia Pictures Corp., supra,* 87 Cal.App.2d at p. 631, 197 P.2d 580) while he was acting as Kemper's agent.

Kemper contends that Amy did not tell Hoyme that she had smoked any cigarettes during the 36 months preceding the application.[FN2] And Kemper points to the *****513** medical report by Amy's physician who, at Amy's request, prescribed a nicotine patch in the year preceding her application, as evidence that Amy smoked more than just "a couple" of cigarettes in the period at issue. Based on the medical report, Justice Blease concluded in his concurring opinion that Kemper was entitled to summary judgment because Amy's cigarette use "was not confined to a couple of cigarettes but was a continuous problem."

> FN2. Although Hoyme testified in his deposition that he did not recall Amy telling him that she had smoked two cigarettes during the 36 months preceding the application, he did remember having "some conversation [with Amy] or a question ... about, you know, having, you know, a cigarette ... in the past, you know, at a special function or something like that...." He also said that he often told applicants that "if you have one [cigarette] once or twice a year, then it's probably not a big deal."

[8] But the question of Amy's cigarette use is a disputed material fact. In response to Kemper's motion for summary judgment, plaintiff declared that Amy had quit smoking in 1991 (more than three years before her life insurance application) and, apart from two cigarettes Amy shared with her sister during the three-year period at issue, she did not resume smoking until after she was diagnosed with terminal cancer in 1997, the year after submitting her application. Plaintiff also submitted a corroborating declaration by Amy's sister, Pamela Inouye, who said that to her knowledge the only cigarettes Amy smoked from 1991 to 1997 were a couple of cigarettes the two of them shared. When, as here, a dispositive factual issue is disputed, summary judgment is improper. (*Guz v. Bechtel National, Inc.* (2000) 24 Cal.4th 317, 334, 100 Cal.Rptr.2d 352, 8 P.3d 1089.)

In their briefs, the parties address the question whether the trial court should have granted Kemper's motion for summary adjudication of certain causes of action in plaintiff's amended complaint. The Court of Appeal did not address these issues, for its conclusion that Amy had materially misrepresented the extent of her smoking during the 36 months preceding her application, thus entitling Kemper to rescind Amy's policy, necessarily disposed of plaintiff's entire complaint. Nor were these issues encompassed in our grant of review. We therefore do not consider them here.

***290 CONCLUSION**

We reverse the judgment of the Court of Appeal, and we remand the matter to that court for further proceedings consistent with this opinion.

WE CONCUR: GEORGE, C.J., BAXTER, WERDEGAR, CHIN, and MORENO, JJ.

Cal.,2005.
O'Riordan v. Federal Kemper Life Assur.
36 Cal.4th 281, 114 P.3d 753, 30 Cal.Rptr.3d 507, 05 Cal. Daily Op. Serv. 5984, 2005 Daily Journal D.A.R. 8177

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C

Court of Appeal, Fifth District, California.
CALIFORNIA DEPARTMENT OF CORRECTIONS and REHABILITATION, Plaintiff and Respondent,
v.
CALIFORNIA STATE PERSONNEL BOARD, Defendant and Respondent.
Darrell Snell et al., Real Parties in Interest and Appellants.

No. F048806.
Feb. 14, 2007.

Background: Disciplinary actions were brought against employees of the California Department of Corrections (CDC), based upon their dishonest denials of underlying charges that had been barred by statute of limitations. State Personnel Board dismissed all charges, including the charges of dishonesty. CDC filed a petition for a writ of administrative mandamus. The Superior Court, Fresno County, No. 03CECG02539, Rosendo Pena, J., ordered the dishonesty charges reinstated. Employees appealed.

Holding: The Court of Appeal, Ardaiz, P. J., held that statute of limitations did not bar disciplinary actions against employees based upon their dishonest denials of underlying charges that were barred by statute of limitations.

Affirmed.

West Headnotes

[1] Administrative Law and Procedure 15A 796

15A Administrative Law and Procedure
15AV Judicial Review of Administrative Decisions
15AV(E) Particular Questions, Review of
15Ak796 k. Law questions in general. Most Cited Cases

Where the facts in administrative proceedings are undisputed, the administrative review board's ultimate conclusion is a pure question of law subject to de novo review.

[2] Appeal and Error 30 842(1)

30 Appeal and Error
30XVI Review
30XVI(A) Scope, Standards, and Extent, in General
30k838 Questions Considered
30k842 Review Dependent on Whether Questions Are of Law or of Fact
30k842(1) k. In general. Most Cited Cases

Officers and Public Employees 283 72.51

283 Officers and Public Employees
283I Appointment, Qualification, and Tenure
283I(H) Proceedings for Removal, Suspension, or Other Discipline
283I(H)3 Judicial Review
283k72.49 Scope of Review
283k72.51 k. Trial or hearing de novo. Most Cited Cases

Court of Appeal is not bound by the State Personnel Board's or the trial court's application and interpretation of a statute.

[3] Officers and Public Employees 283 72.12

283 Officers and Public Employees
283I Appointment, Qualification, and Tenure
283I(H) Proceedings for Removal, Suspension, or Other Discipline
283I(H)1 In General
283k72.11 Notice or Charge
283k72.12 k. In general. Most Cited Cases

Statute of limitations that applied to adverse actions against state employees of California Department of Corrections (CDC) did not bar disciplinary actions against employees based upon their dishonest

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denials of underlying charges that were barred by statute of limitations; consistent with plain language of statute of limitations and public policy considerations, extensive lying during the course of investigative interviews that occurred within the applicable statute of limitations of the matter being investigated did not merge with the underlying offenses. West's Ann.Cal.Gov. Code § 19635.
See 3 Witkin, Cal. Procedure (4th ed. 1996) Actions, § 405 et seq.; Cal. Jur. 3d, Limitation of Actions, § 125 et seq.

[4] Statutes 361 181(1)

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k180 Intention of Legislature
361k181 In General
361k181(1) k. In general. Most Cited Cases

Statutes 361 184

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k180 Intention of Legislature
361k184 k. Policy and purpose of act. Most Cited Cases

When interpreting a statute, courts must ascertain legislative intent so as to effectuate the law's purpose.

[5] Constitutional Law 92 2473

92 Constitutional Law
92XX Separation of Powers
92XX(C) Judicial Powers and Functions
92XX(C)2 Encroachment on Legislature
92k2472 Making, Interpretation, and Application of Statutes
92k2473 k. In general. Most Cited Cases
(Formerly 92k70.1(2))

Statutes 361 176

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k176 k. Judicial authority and duty. Most Cited Cases

Statutes 361 186

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k180 Intention of Legislature
361k186 k. Cases and matters omitted. Most Cited Cases

In the construction of a statute the office of the judge is simply to ascertain and declare what is contained therein, not to insert what has been omitted, or to omit what has been inserted.

[6] Statutes 361 188

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k187 Meaning of Language
361k188 k. In general. Most Cited Cases

Statutes 361 190

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k187 Meaning of Language
361k190 k. Existence of ambiguity. Most Cited Cases

Statutes 361 205

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k204 Statute as a Whole, and Intrinsic Aids to Construction
361k205 k. In general. Most Cited Cases

Legislative intent will be determined so far as possible from the language of statutes, read as a whole, and if the words are reasonably free from ambiguity and uncertainty, the courts will look no further to ascertain its meaning.

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[7] Statutes 361 174

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k174 k. In general. Most Cited Cases

When construing a statute, the court should take into account matters such as context, the object in view, the evils to be remedied, the history of the times and of legislation upon the same subject, public policy, and contemporaneous construction.

[8] Statutes 361 208

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k204 Statute as a Whole, and Intrinsic Aids to Construction
361k208 k. Context and related clauses. Most Cited Cases

When construing a statute, the various parts of the enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole.

[9] Limitation of Actions 241 1

241 Limitation of Actions
241I Statutes of Limitation
241I(A) Nature, Validity, and Construction in General
241k1 k. Nature of statutory limitation. Most Cited Cases

There are several policies underlying statutes of limitation; one purpose is to give defendants reasonable repose, thereby protecting parties from defending stale claims, and such statutes also stimulate plaintiffs to pursue their claims diligently.

[10] Limitation of Actions 241 1

241 Limitation of Actions
241I Statutes of Limitation
241I(A) Nature, Validity, and Construction in General
241k1 k. Nature of statutory limitation. Most Cited Cases

A countervailing factor to those factors justifying statutes of limitation, is the policy favoring disposition of cases on the merits rather than on procedural grounds.

****666** Wendell J. Llopis, for Real Parties in Interest and Appellants.

No appearance for Defendant and Respondent.

K. William Curtis, Warren C. Stracener, Wendi L. Ross, and Christopher E. Thomas, for Plaintiff and Respondent.

***799 OPINION**

ARDAIZ, P.J.

INTRODUCTION

In a case of first impression, we are asked to determine whether Government Code section 19635 FN1 bars disciplinary actions against employees of the California Department of Corrections (CDC) FN2 based upon their dishonest denials of underlying charges where the underlying charges are barred by section 19635. We do not find ****667** that extensive lying during the course of investigative interviews that occurred within the applicable statute of limitations of the matter being investigated merges with the underlying offense. This is consistent with case law saying that dishonesty is a separate act. Thus, section 19635 does not bar the disciplinary actions in this case.

FN1. All section citations are from the Government Code, unless otherwise stated.

FN2. CRC is currently known as the California Department of Corrections and Rehabilitation. For the purposes of consistency with the prior case history, we will continue to refer to it as CRC.

STATEMENT OF THE CASE

The facts are undisputed. Darrell Snell (Snell), Wayne Villarreal (W. Villarreal), Stephanie Rodriguez (Rodriguez), and Rene Villarreal (R. Villarreal), are employees of CDC. Snell and W. Villarreal are peace officer employees, and Rodriguez and R. Villarreal are civilian employees.

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***800** Pursuant to section 19574, subdivision (a), CDC served various written notices of adverse actions (Notices) imposing disciplinary sanctions upon Snell, W. Villarreal, Rodriguez and R. Villarreal for participating in a pyramid scheme from approximately June of 1996 to September of 1996. Snell and W. Villarreal were suspended for 180 work days, Rodriguez was suspended for 120 work days, and R. Villarreal was suspended for 140 work days.

The Notices alleged various causes for discipline based upon the appellants' participation in the pyramid scheme. These causes included section 19572, subdivision (d)—inexcusable neglect of duty; section 19572, subdivision (r)—incompatible activities; and section 19572, subdivision (t)—other failure of good behavior.

The Notices also alleged section 19572, subdivision (f)—dishonesty, as a cause of discipline. CDC alleged that the appellants were dishonest at various investigative interviews conducted by CDC, in calendar years 1997 and 1998, when they denied any participation in the pyramid scheme.

As alleged in the Notice, Snell was interviewed on August 8, 1997 as a witness. He denied any involvement and firsthand knowledge of the pyramid scheme. He participated in an investigatory interview on December 30, 1997. At this second interview, he denied any involvement in the pyramid scheme.

W. Villarreal was interviewed on December 30, 1997. He denied that he was ever approached or recruited into the pyramid scheme. He denied that he was familiar with the pyramid scheme, or had any knowledge of the pyramid scheme other than through rumors. He denied ever attending any pyramid scheme meeting. He further denied discussing or recruiting for the pyramid scheme on the job. He denied that he conducted or hosted pyramid scheme parties or meetings at his home. He denied that he handled monies relative to the pyramid scheme. Although he was advised that several persons had testified that he was actively involved in the pyramid scheme, and had stated that they had been at his home for recruiting parties for the pyramid scheme, W. Villarreal continued to deny any firsthand knowledge of the pyramid scheme or involvement in it at any level.

Rodriguez was interviewed on November 25, 1997. She denied any involvement in the pyramid scheme including ever being approached, recruiting, investing, attending a meeting during which the pyramid scheme was explained and hosting a pyramid scheme party at her home.

R. Villarreal was interviewed on February 11, 1998. During this interview, she denied all involvement and first hand knowledge of the pyramid scheme. She denied investing in the pyramid scheme. She denied recruiting for the ***801** pyramid scheme. She denied attending or hosting any pyramid scheme parties. She denied ****668** ever having received or handled monies for the pyramid scheme.

Snell was served with a notice on December 14, 1999. W. Villarreal was served with a notice on December 15, 1999. Rodriguez was served with a notice on December 2, 1999, and R. Villarreal was served with a notice on December 13, 1999.

Pursuant to section 19575, subdivision (a), the appellants filed timely appeals with the State Personnel Board ("SPB") requesting an administrative hearing to contest the validity of the Notices. The four appeals were consolidated for hearing.

An administrative hearing was held before a duly appointed Administrative Law Judge ("ALJ"). Appellants repeated their denials at the hearing. The ALJ issued proposed decisions sustaining all disciplinary causes of action contained in the Notices, but modified the imposed suspensions. The ALJ found that Snell's and Rodriguez's denials of involvement in the pyramid scheme were not credible in light of testimony by numerous witnesses. The ALJ found that W. Villarreal and R. Villarreal were dishonest when they denied any knowledge of, or participation in, the pyramid scheme. On July 11, 2001, SPB adopted the proposed decisions of the ALJ, but further modified the imposed suspensions.

The appellants filed a timely Petition for Rehearing with SPB pursuant to section 19568. SPB granted appellants' Petition for Rehearing and set the appeals for further hearing and argument.

On August 6, 2002, SPB issued a final decision dismissing all charges contained in the Notices, including the charges of dishonesty. SPB found that the Notices were not served within the three-year limita-

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tion period of section 19635, and that the facts did not warrant a finding that CDC was entitled to the fraud discovery exception of that statute. SPB held that dishonesty during an investigatory interview is "a separate and serious charge," but that the dishonesty charges were also untimely. SPB found persuasive appellants' argument that to allow the charges of dishonesty, based upon the appellants' denials of participating in the pyramid scheme, to survive the dismissal of the underlying charges "would defeat the purposes of the statute of limitations set forth in Section 19635."

SPB reasoned that for CDC to prove the appellants' denials to be false and dishonest, CDC must prove the appellants' participation in the pyramid scheme to be factually true. SPB held that such a result would force the ***802** appellants to litigate and defend matters whose litigation is already barred by the statute of limitations. According to SPB, "[t]his 'bootstrapping' of the dishonesty charges to the underlying charges would, in turn, serve to eviscerate one of the primary purposes of a statute of limitations—to prevent the hardship and injustice of having to defend against stale claims after memories have faded or evidence has been lost."

On July 11, 2003, CDC filed a Petition for Writ of Administrative Mandamus seeking to set aside SPB's final decision. CDC's Petition was heard on May 13, 2005, before the Honorable Rosendo Pena of the Fresno County Superior Court.

On July 5, 2005, Judge Pena held that SPB correctly decided that all disciplinary charges related to the employees' participation in the pyramid scheme are properly barred by the statute of limitations of section 19635, and that CDC is not entitled to the fraud discovery exception to that statute. However, Judge Pena also held that SPB erred as a matter of law when it dismissed the dishonesty charges as untimely. The trial court ordered the dishonesty****669** charges reinstated against appellants.

Appellants filed a timely Notice of Appeal on September 6, 2005. They appeal only from Judge Pena's decision holding that the dishonesty charges were not barred by section 19635.

DISCUSSION
I.

Standard of Review

[1][2] Neither the appellants nor the respondent contest the factual determinations made by the trial court, or those made by SPB. Where the facts are undisputed, SPB's ultimate conclusion is a pure question of law subject to de novo review. (*Moosa v. State Personnel Bd.* (2002) 102 Cal.App.4th 1379, 1384, 126 Cal.Rptr.2d 321, 325.) Furthermore, we are not bound by SPB's or the trial court's application and interpretation of a statute. (*Burden v. Snowden* (1992) 2 Cal.4th 556, 562, 7 Cal.Rptr.2d 531, 535.)

II.
Alameida v. State Personnel Board

[3] Appellants argue that section 19635 bars the dishonesty charges against them. According to appellants, the dishonesty charges are based upon lies that ***803** merged with, or are derivative of, the underlying misconduct. Given that section 19635 bars charges based upon the underlying misconduct where appellants argue that section 19635 also bars charges based upon lies that merge with, or are derivative, of the underlying misconduct. In support, appellants cite *Alameida v. State Personnel Bd.* (2004) 120 Cal.App.4th 46, 15 Cal.Rptr.3d 383 (*Alameida*).

Alameida involved the interpretation of section 3304, subdivision (d). FN3 In *Alameida,* the "CDC sought to dismiss an employee ... Nathan A. Lomeli, for immorality, discourteous treatment of the public, failure of good behavior, and dishonesty during interviews investigating these charges." (*Alameida, supra,* 120 Cal.App.4th at p. 50, 15 Cal.Rptr.3d 383.) Lomeli allegedly committed sexual offenses on September 18, 1998, and lied about them by falsely denying them in an interview conducted by CDC on July 12, 2000. (*Id.* at p. 51, 15 Cal.Rptr.3d 383.) Lomeli was served with a Notice of Adverse Action on November 15, 2000. (*Ibid.*) Lomeli opposed the adverse employment action, and an administrative hearing was held before an ALJ. (*Ibid.*)

FN3. Section 3304, subdivision (d) provides in relevant part that: "[N]o punitive action, nor denial of promotion on grounds other than merit, shall be undertaken for any act, omission, or other allegation of misconduct if the investigation of the allegation is not completed within one year of the public agency's discovery by a person authorized to initiate an investigation of the allegation of

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an act, omission, or other misconduct. This one-year limitation period shall apply only if the act, omission, or other misconduct occurred on or after January 1, 1998."

"Although the November 15, 2000, Notice of Adverse Action was served less than one year after Lomeli's alleged dishonesty in denying the sex offenses during the investigatory interview on July 12, 2000, the ALJ determined the dishonesty charge could not survive as a separate basis for discipline, because it flowed directly from the investigation of the September 1998 sex offense, and it would defeat the purpose of [the Public Safety Officers Procedural Bill of Rights Act (§ 3300 *et seq.*) (the Act)] to allow the employer to circumvent the one-year limitations period by allowing the agency to prove the underlying charges in order to demonstrate the employee was dishonest ****670** in denying the charges." (*Alameida, supra,* 120 Cal.App.4th at pp. 51–52, 15 Cal.Rptr.3d 383.) SPB adopted the ALJ's decision. (*Id.* at p. 52, 15 Cal.Rptr.3d 383.)

CDC sought a writ of administrative mandamus, and was denied. The *Alameida* court affirmed. It rejected CDC's argument that the one-year statute of limitations in section 3304, subdivision (d) was extended pursuant to section 3304, subdivision (g), which provides an extension where CDC reopens an investigation based upon significantly new evidence that resulted from the public safety officer's predisciplinary response. (*Alameida, supra,* 120 Cal.App.4th at pp. 60–61, 15 Cal.Rptr.3d 383.)

***804** The *Alameida* court went on to note that "peace officers in interrogations under the Act do not have a right to remain silent." (*Id.* at p. 62, 15 Cal.Rptr.3d 383.) It cited the California Supreme Court case of (*Lybarger v. City of Los Angeles* (1985) 40 Cal.3d 822, 827, 221 Cal.Rptr. 529, 531–32) in which our Supreme Court held that "[a]s a matter of constitutional law, it is well established that a public employee has no absolute right to refuse to answer potentially incriminating questions posed by his employer. Instead, his self-incrimination rights are deemed adequately protected by precluding any use of his statements at a subsequent criminal proceeding." Furthermore, "although the officer under investigation is not compelled to respond to potentially incriminating questions, and his refusal to speak cannot be used against him *in a criminal proceeding,* nevertheless such refusal may be deemed insubordination leading to punitive action by his employer." (*Lybarger v. City of Los Angeles, supra,* 40 Cal.3d at p. 828, 221 Cal.Rptr. 529, 710 P.2d 329.)

Drawing upon this precedent, the *Alameida* court stated that "[i]t is unseemly to force a person to answer an allegation of misconduct and then punish him for denying the allegation." (*Alameida, supra,* 120 Cal.App.4th at p. 62, 15 Cal.Rptr.3d 383, fn. omitted.) The *Alameida* court also agreed "with the ALJ and the trial court that the denial in these circumstances does not constitute separate actionable misconduct but in effect merges with or is derivative of the alleged underlying misconduct. As phrased by the ALJ, the dishonesty charge flows directly from the investigation of the assault. To allow the dishonesty charge to survive would defeat the purpose of the limitations period, which is to ensure that conduct that could result in discipline should be adjudicated when memories are fresh." (*Alameida, supra,* 120 Cal.App.4th at p. 62, 15 Cal.Rptr.3d 383.) [FN4]

FN4. SPB also was concerned that the " 'bootstrapping' of the dishonesty charges to the underlying charges would, in turn, serve to eviscerate one of the primary purposes of a statute of limitations—to prevent the hardship and injustice of having to defend against stale claims after memories have faded or evidence has been lost."

Although appellants concede that section 3304, subdivision (d) is not the applicable statute of limitations in this case,[FN5] nevertheless, appellants argue that the holding of the *Alameida* court—that a denial of underlying charges merges with the underlying offenses—can be generalized to ****671** all statutes of limitations, including section 19635. We disagree. There is nothing in the plain language of section 19635, or in the purposes of statutes of limitations, that supports a finding that extensive lying during investigatory interviews ***805** merges with the underlying misconduct that is being investigated. Thus, we do not interpret section 19635 to bar the dishonesty charges here.

FN5. Section 3304, subdivision (d) does not apply in this case for several reasons. First, Snell and W. Villarreal are the only public safety officers in this appeal, and section

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3304, subdivision (d) only applies to public safety officers. (§ 3301.) Second, their dishonesty occurred during interviews on December 30, 1997, and so was not within the purview of section 3304, subdivision (d), which only applies to misconduct occurring on or after January 1, 1998.

III.
Interpreting Statutes of Limitations

[4][5][6][7][8] "The principles governing the proper construction of a statute are well established...." (*California Teachers Assn. v. Governing Bd. of Golden Valley Unified School Dist.* (2002) 98 Cal.App.4th 369, 375, 119 Cal.Rptr.2d 642, 646.) " 'Courts must ascertain legislative intent so as to effectuate a law's purpose. [Citations.] "In the construction of a statute ... the office of the judge is simply to ascertain and declare what is ... contained therein, not to insert what has been omitted, or to omit what has been inserted; ..." [Citation.] Legislative intent will be determined so far as possible from the language of statutes, read as a whole, and if the words are reasonably free from ambiguity and uncertainty, the courts will look no further to ascertain its meaning. [Citation.] " 'The court should take into account matters such as *context,* the object in view, the evils to be remedied, the history of the times and of *legislation upon the same subject,* public policy, and contemporaneous construction.' " [Citations.] "Moreover, the various parts of a statutory enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole." [Citations.]' " (*Id.* at pp. 375–376, 119 Cal.Rptr.2d 642.)

[9][10] With respect to statutes of limitations, our Supreme Court has held that "[t]here are several policies underlying such statutes. One purpose is to give defendants reasonable repose, thereby protecting parties from 'defending stale claims, where factual obscurity through the loss of time, memory or supporting documentation may present unfair handicaps.' [Citations.] A statute of limitations also stimulates plaintiffs to pursue their claims diligently. [Citations.] A countervailing factor, of course, is the policy favoring disposition of cases on the merits rather than on procedural grounds. [Citations.]" (*Fox v. Ethicon Endo–Surgery, Inc.* (2005) 35 Cal.4th 797, 806, 27 Cal.Rptr.3d 661, 666–67.)

Thus, we interpret section 19635 by examining its plain language and in light of its purposes.

A.
Section 19635

Section 19635 states:

"No adverse action shall be valid against any state employee for any cause for discipline based on any civil service law of this ***806** state, unless notice of the adverse action is served within three years after the cause for discipline, upon which the notice is based, first arose. Adverse action based on fraud, embezzlement, or the falsification of records shall be valid, if notice of the adverse action is served within three years after the discovery of the fraud, embezzlement, or falsification."

By its plain language, section 19635 provides that disciplinary action can be imposed on a state employee only if the employee was timely served with written notice of the disciplinary action. The written notice must be served upon the state employee within three years after the ****672** cause for discipline first arose, or three years after discovery of fraud, embezzlement, or falsification. (§ 19635.) Moreover, the disciplinary action must be based upon a civil service law of California, or based upon fraud, embezzlement or the falsification of records. (*Ibid.*)

Dishonesty is specifically listed as a cause for discipline in the California civil service law. (§ 19572, subd. (f).) Thus, section 19635 applies to any adverse action based upon dishonesty.

Here, appellants were served with Notices containing dishonesty charges within three years of their dishonest denials at investigatory interviews. Thus, under the plain language of section 19635, appellants could be disciplined for their lies.

B.
The Purpose of Statutes of Limitations Does No Support Barring The Disciplinary Charges

Although appellants concede that dishonesty is categorized as a separate charge under section 19572, they argue that this does not mean that "dishonesty is a separately actionable cause for discipline in the context of the statute of limitations issue presented in this appeal." Appellants contend that section 19635 should be interpreted to bar the dishonesty charges because,

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here, their lies at the investigatory interviews merged with the underlying misconduct being investigated. According to appellants, to interpret section 19635 otherwise would eviscerate the purposes of statutes of limitations. We disagree.

Lying is a separate and distinct offense from the underlying offense. (§ 19572, subd. (f); *Timothy Welch* (1992) SPB Dec. No. 92–03; *LaChance v. Erickson* (1998) 522 U.S. 262, 267–268, 118 S.Ct. 753 [holding that a federal employee can be charged with dishonesty for giving false denials of charged misconduct during an agency's investigatory interview even though the denials were not made under oath; noting that “any ***807** claim that employees not allowed to make false statements might be coerced into admitting misconduct, whether they believe that they are guilty or not, in order to avoid the more severe penalty of removal for falsification is entirely frivolous.”])

Moreover, the lying here involved repeated dishonest denials of allegations relating to the underlying misconduct. We do not find that such repeated denials are mere denials of underlying charges to which *Alameida* limited itself. (*Alameida, supra,* 120 Cal.App.4th at p. 62 fn. 10, 15 Cal.Rptr.3d 383 But cf. *Brogan v. U.S.* (1998) 522 U.S. 398, 118 S.Ct. 805, 139 L.Ed.2d 830 [rejecting argument that federal statute criminalizing making of false statements has an unwritten exception for the “ ‘exculpatory no,’ ” a simple denial of guilt.])

Also, appellants were charged only a few months after the statute of limitations had expired on the underlying misconduct, and they were charged with lying within the limitations period of section 19635. These factual circumstances distinguish this case from *Alameida.* The *Alameida* court, and the SPB in this case, was concerned that discipline should be adjudicated while memories are fresh in order to prevent the hardship and injustice of having to defend against stale claims. (*Alameida, supra,* 120 Cal.App.4th at p. 62, 15 Cal.Rptr.3d 383.) In this case, however, appellants do not contend that CDC presented witnesses at the hearing before the ALJ whose memories have faded, or that the evidence presented at the hearing was stale, or that exculpatory evidence was lost. As another appellate court has observed, “the policy behind statutes of limitation, which the United States Supreme Court long ago noted is to ‘promote justice by preventing ****673** surprises through the revival of claims that have been allowed to slumber until evidence has been lost, memories have faded and witnesses have disappeared.’ [Citations.] No claim slumbered here. No evidence was lost. No witnesses disappeared. Not by a long shot.” (*Parra v. City and County of San Francisco* (2006) 144 Cal.App.4th 977, 998, 50 Cal.Rptr.3d 822, 838.) [FN6]

FN6. We note that the Legislature determines limitations period for policy rationales other than just prevention of surprises through the revival of stale claims. For example, an examination of the limitations periods for crimes suggests that the limitations period depends, to some extent, on the gravity of the crime. Thus, we have no statute of limitations for very serious crimes such as murder (Pen.Code, § 799), six-year limitations period for crimes such as arson causing bodily injury (Penal Code, § 800), and three-year limitations period for other lesser crimes (Pen.Code, § 801), even though witnesses' memories may have deteriorated in the same manner for these crimes.

Appellants argue that permitting dishonesty claims to survive when the dishonest denials occurred within the limitations period of the underlying charges would effectively extend the three-year limitations period in section 19635 into a six-year limitations period for dishonesty charges. According to ***808** appellants, such a holding would permit “a public agency [to] interview an employee about a prior act of misconduct just days before the lapse of the three year limitations period upon that act of prior misconduct, then wait another three years before serving the employee with a notice of adverse action alleging charges of dishonesty based upon the employee's denial at the interview, of any involvement in that prior act of misconduct. This puts an employee in the position of having to defend against prior acts of misconduct over six years old.”

Appellants overstate their case. The hypothetical situation presented by appellants is not the situation that occurred in the present case. (*Sulier v. State Personnel Bd.* (2004) 125 Cal.App.4th 21, 30, 22 Cal.Rptr.3d 615.) Here, appellants only had to defend statements that they made approximately two years before, well within the three-year limitations period of

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section 19635.

Finally, public policy considerations—including the fact that correctional officers are involved, California's policy against hiring dishonest employees, and the policy favoring honesty over dishonesty—support our finding that extensive lying does not merge with underlying offense.

First, this case involves state employees who work in our correctional facilities. Appellants are public employees to whom we entrust the care and rehabilitation of criminals. Moreover, two of the appellants are peace officers who are held to a higher standard of conduct than other public employees. (*Flowers v. State Personnel Bd.* (1985) 174 Cal.App.3d 753, 759, 220 Cal.Rptr. 139, 142.) As such, to find that their lies merge with underlying misconduct and thus are barred by section 19635 would permit appellants to conduct themselves in a manner unbefitting correctional employees.

Second, "[p]ublic employees are trustees of the public interest and thus owe a special duty of integrity." (*Long Beach City Employees Assn. v. City of Long Beach* (1986) 41 Cal.3d 937, 952, 227 Cal.Rptr. 90, 99.) Moreover, "[b]y its enactment of section 19572, subdivision (f), the Legislature indicated a strong public policy against having dishonest employees in the state service." (*Gee v. California State Personnel Bd.* (1970) 5 Cal.App.3d 713, 719, 85 Cal.Rptr. 762, 769.) To permit appellants who lied during investigatory interviews and who were charged with violations of ****674** section 19572, subdivision (f), to escape unscathed would be contrary to the strong public policy against having dishonest public employees.

Lastly, a contrary finding would encourage lying during investigative interviews because there are no consequences for lying if the lie is not caught prior to the expiration of the limitations period on the underlying misconduct. For example, a finding that the lies merge with the underlying offense would ***809** encourage a rational person to lie where the investigatory interview into misconduct occurred towards the end of the limitations period, as it would be unlikely for the investigator to discover that the denials were lies within the limitations period.

Thus, policy considerations support finding that appellants' extensive lying do not merge with the underlying misconduct. Therefore, section 19635 does not bar the dishonesty charges in this case.

DISPOSITION

The judgment is affirmed.

WE CONCUR: LEVY, and GOMES, JJ.

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